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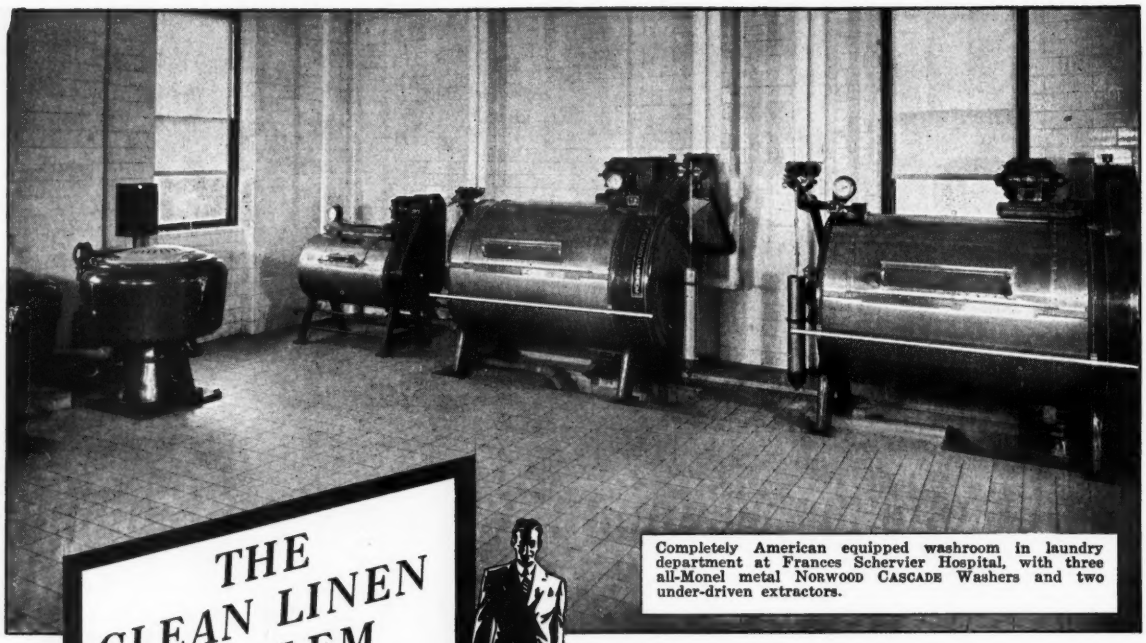
TORONTO, FEBRUARY, 1942

THE CANADIAN HOSPITAL

· OFFICIAL JOURNAL · CANADIAN HOSPITAL COUNCIL ·



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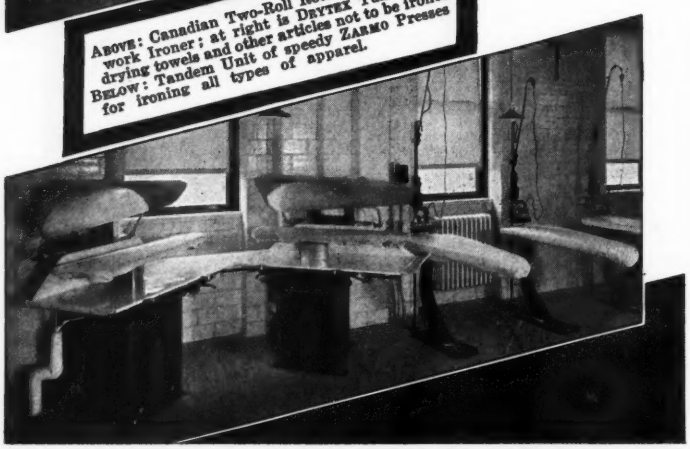
ABOVE: Canadian Two-Roll Return Apron Flat-work Ironer; at right is DRYTEX Tumbler for drying towels and other articles not to be ironed
BELOW: Tandem Unit of speedy ZARMO Presses for ironing all types of apparel.



Before construction began on the new Frances Schervier Hospital, New York City, provisions for always maintaining an adequate supply of clean linens at minimum cost were drawn right into the plans.

It was our privilege to submit complete recommendations for handling the hospital's soiled linens most economically, and returning them to service on shortest possible schedule. Our preliminary service included a carefully worked out layout of the proposed laundry department. In line with our recommendations, the high production equipment pictured on this page was installed.

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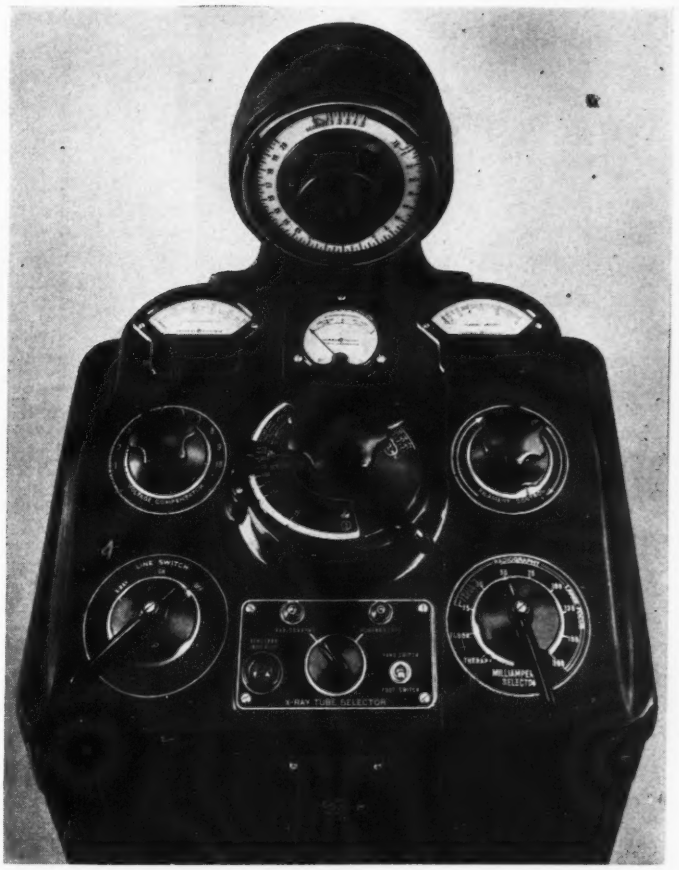
G-E Announces New 200-Milliampere Mobile Centralinear Control Unit



Eliminates Calibration Charts; Speeds-up, Simplifies Operation

● Real News? You bet it is. And there is much of interest in the unusual accuracy and precision operation that is provided by the engineering advancements introduced in the new G-E Mobile Centralinear Control.

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You will want to know all the facts about the simplified, error-free, precision operation of the G-E Mobile Centralinear Control. And to get them, here's all you have to do: Write, today, requesting your local G-E X-Ray representative to call, or ask for your copy of the new bulletin which describes and illustrates this new unit. Address Department L82.

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Vol. 19 FEBRUARY, 1942 No. 2

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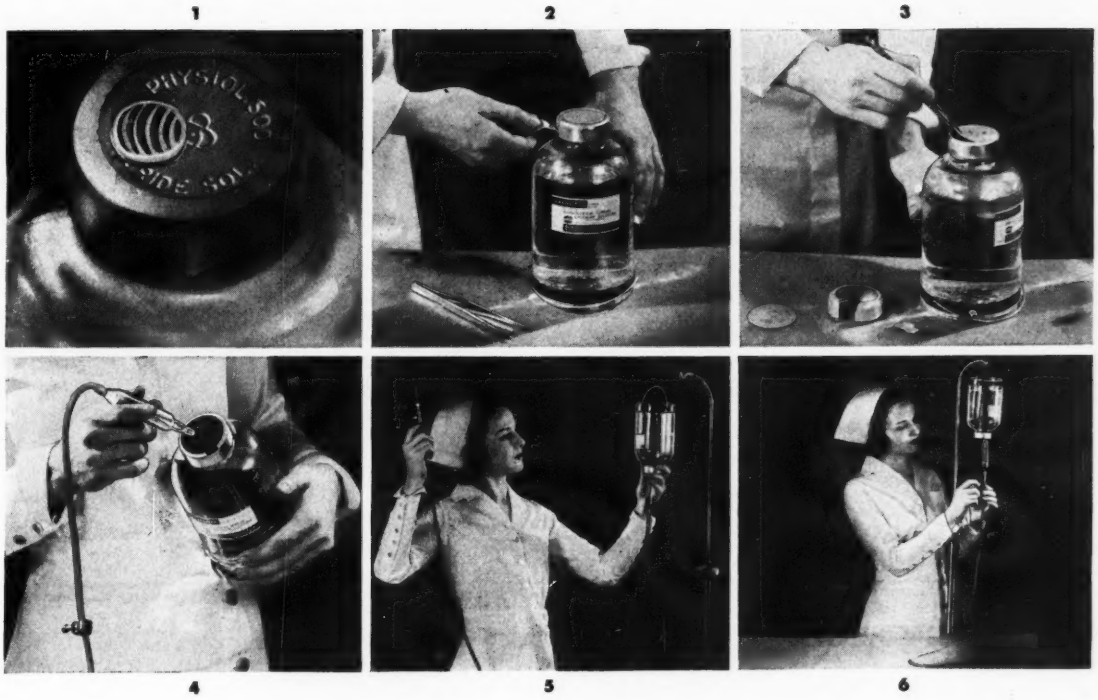

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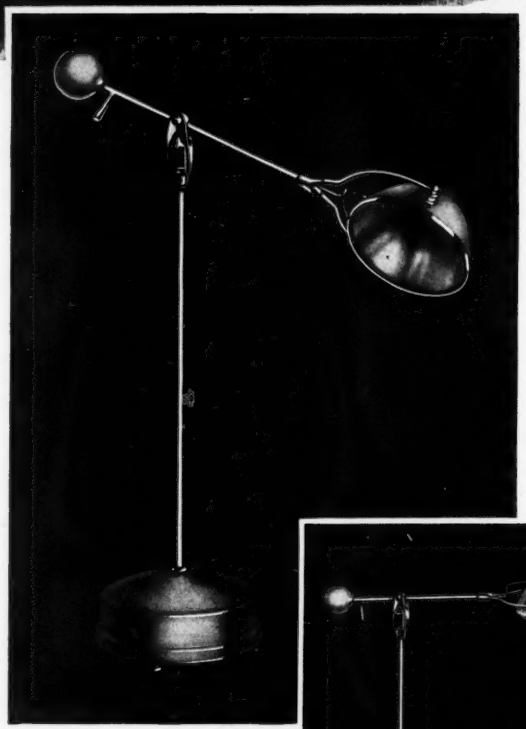

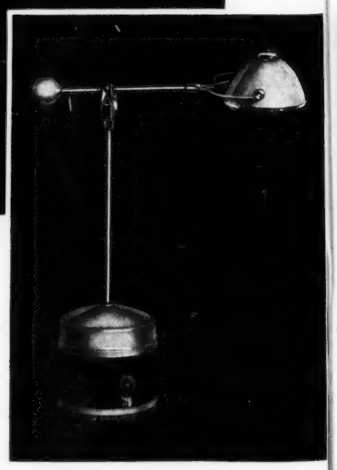

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Harvey Agnew, M.D., *Editor*

The CANADIAN HOSPITAL

Toronto, February, 1942 Vol. 19 No. 2

Hospitals Seriously Affected by Government Order Fixing Room Charges

As briefly announced in a "last minute" insertion in our January issue, the Controller of Services under the Wartime Prices and Trade Board has ruled that public hospitals may not raise their charges for room accommodation. Moreover it has been ruled that hospitals must maintain these services without any reduction in the quality or standard of the service rendered! The charges for extras have not been fixed—as yet. The room rates to which hospitals must adhere, or return, are those prevailing during the period September 15 to October 11, 1941.

This ruling has evoked much consternation in the hospital field. It is realized that inflation can be controlled only by a rigid control of prices; it is realized, too, that the Administrator of Services in this interpretation is trying to protect the public. But hospitals are being asked to do what for most of them will be an impossibility. Their commendable reluctance to follow the lead of industry and trade in steadily raising prices to meet or anticipate rising costs during the first two years of the war is now to further penalize them. Hospital costs have risen markedly during the past two and one-half years; they have risen much more extensively than has the general cost of living, as drugs, instruments and other articles required by hospitals have risen several hundred per cent. Averaging out all expenditures, the cost of operation, as based on the many calculations reported, has increased between 25 and 30 per cent instead of the 15 per cent for the population as a whole. The exemption of hospitals from the cost-of-living bonus requirement has really not helped the hospitals to any extent, for most of them have had to voluntarily increase wages to a reasonably comparable extent, partly in fairness to their employees and partly in order to hold them.

At every provincial convention this past year, hospitals reported that they were providing services at less than cost. Public and semi-public receipts have been far below costs and so have semi-private charges in many hospitals. Many hospitals have reached the limit of their credit at the bank. Had it not been for an increase in private room patronage, most public hospitals could not have carried on at the old rates. As most hospitals now have their private accommodation fully occupied, no increase in patronage can be expected and, therefore, no additional revenue to meet the heavier and still rising costs of operation and replacement can be anticipated. How hospitals can continue to operate at less than cost and with no surplus or potential dividends from which to meet this deficit we do not know. *Either the government must permit a modest raising of rates for services now operated at a loss without jeopardizing the right of wholesalers to quote to hospitals prices kept down by the federal subsidy, or there must be a lowering of quality in the service.*

Unless rates can be adjusted, hospital services cannot do otherwise than become lowered in quality of service. This will occur irrespective of the effort of the hospital to comply with the rulings of the government, for every enlistment of an experienced supervisor, of a resident doctor, laboratory or X-ray technician, of a trained orderly or of a good cook means the loss of someone who, in the great majority of instances, cannot be replaced. To further cripple hospital service by

Hospitals finding it difficult to carry on, or finding that this restriction is forcing them to lower the quality of their service, would be well advised to send this information to the Canadian Hospital Council.

making it impossible for hospitals to go to the expense of training anyone for these positions, or to send selected personnel away for short intensive courses, or to pay the higher wages now required to obtain or hold skilled help, will prove disastrous.

Moreover most hospitals are getting far behind on their replacements of wornout equipment. If some flexibility in setting rates to meet costs is not possible, needed equipment cannot be purchased.

Despite the seemingly insurmountable task of trying to accomplish the impossible, our hospitals will attempt with all sincerity to meet this situation. At a time like this every institution, as well as every individual, must be a soldier. Following the receipt of this information, the Toronto Hospital Council featured on its January agenda a discussion of how, if anywhere, still further economies could be effected. Other hospitals and other organizations will do likewise, although the opportunities for further economies without affecting the service given are not very obvious.

The Administrator of Services and his associates, Mr. McCutcheon and Mr. McMullen, despite their regrettable ruling, have been very courteous in discussing hospital problems and have expressed a willingness to review the situation of any individual hospital requesting the privilege of raising rates. Wrote Mr. James Stewart, the Administrator:

"I realize that difficulties may confront a number of hospitals throughout the country because of present conditions which will affect them in numerous ways, for which reason any applications for increases which may be forwarded to us will receive careful consideration."

At the same time hospitals are told that they must have sound data that will bear the closest analysis before such application will be considered.

The matter is not yet closed and it is hoped that a more flexible interpretation can be given.

Hospital Salaries and Wages

Wages not fixed but salaries adjustable under certain conditions only

Rulings have been received with respect to hospital wages and salaries.

WAGES come under the National War Labour Board. Public hospitals come under the clause "any hospital or religious, charitable or educational institution or association operated on a non-profit basis" [clause 2, (III), (IV)], and therefore are *exempt* from Order P.C. 8253 fixing wages. By the same order hospitals are not required to pay the cost-of-living bonus. In actual practice many hospitals have voluntarily given a commensurate increase.

SALARIES come under the Income Tax Division of the Department of National Revenue. The Wartime Salaries Order, P.C. 9298, fixing salaries as of the basic period September 15—October 11 *applies* to hospitals, except those which are "agencies" of a province or municipality. The Commissioner of Income Tax has interpreted this to be when "a province or a municipality must bear any deficits in operation. The mere fact of receiving subsidies is not sufficient in itself to make a hospital a provincial or municipal agency".

Hospitals which are not agencies of muncipalities or the province (in the main, other than municipal, union or mental hospital) must not increase salaries of salaried officials after November 6th, 1941, *"unless there has been a bona fide promotion"*. If there has been a promotion a salary increase may be given.

Any hospital desiring to increase salaries of officials and considering itself exempt from the Order, i.e. an agency of a province or municipality, "should obtain from an official of the province or municipality a statement confirming that its deficits are borne by the province or municipality and citing the Statute or by-law governing such hospital".

WAGE or SALARY? Under which heading should an employee or official be considered? It has been ruled, based on P.C. 8253, that any person *above the rank of foreman or comparable ranks* is on "salary". A person who is a foreman, or holds a comparable rank, or is below that status, is on a "wage".

This simplifies but does not entirely clarify the situation as it relates to hospital organization. Obviously the superintendent is above the rank of foreman. The ward and other supervisors might be considered as foremen; so might the laundry head, the engineer, the dietitian, the office manager, the chief technician, the head orderly and the housekeeper. There may be some ambiguity about the others; for instance the director of the school for nurses. In one sense she is a foreman and eligible for an increase; in another, she is above that rank and not eligible.

Where there is confusion in interpretation of status, the Wartime Salaries Order, P.C. 9298, states [Sec. 1 (b)] that any decision of the National War Labour Board or a Regional War Labour Board shall apply; failing that the Minister of National Revenue may decide. If there be no decision (note this)

"an employee receiving a total salary of more than $250 per month shall be deemed to be above the rank of foreman or comparable ranks;"

Maintenance, bonuses and emoluments shall be included in determining the salary.

How About in Canada?

It has been announced that eighty (80) hospitals in New York City alone have emergency medical field units. Nearly all of these were established before the United States entered the war. What Canadian city could show a comparable record?

How Can the Internship be Improved?

Dr. Nathan Smith of New York City outlines an excellent plan for initiating the intern into his duties and for continuing his education.

THE introduction of the new intern to his hospital responsibilities and the organization and planning of his education during his internship are frequently not as well planned as they might be. In an endeavour to clarify these requirements, the deputy medical superintendent of Morrisania City Hospital in New York, Dr. Nathan Smith, has prepared a series of photographs and explanatory material indicating the system which has been followed for a number of years in that hospital.

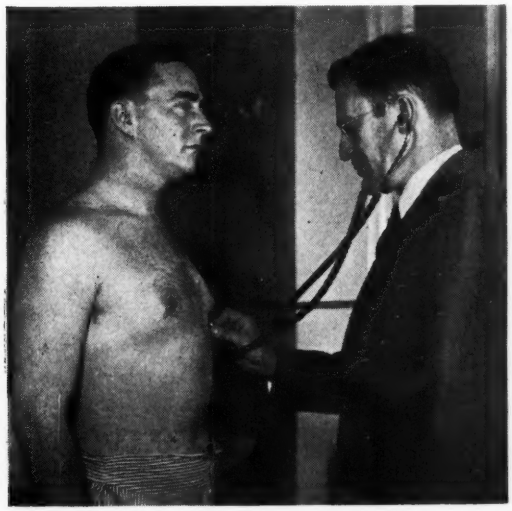
With the thought that these procedures would be of interest to readers of THE CANADIAN HOSPITAL, Dr. Smith has kindly permitted us to reproduce a number of these photographs in this issue.

Introducing the New Intern

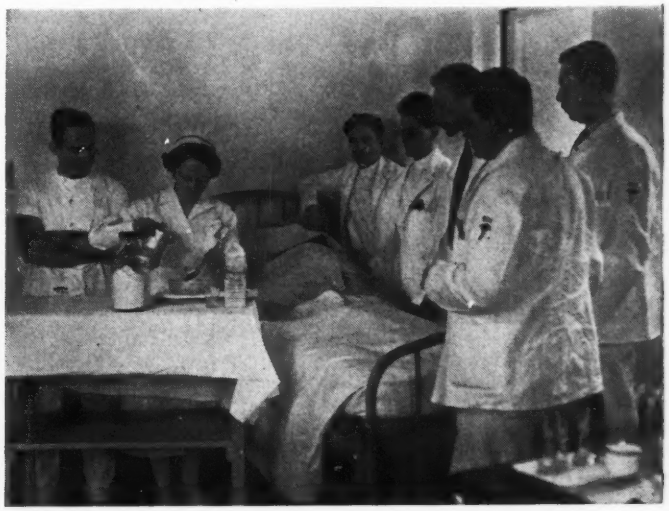
An outstanding feature of the programme followed is that prior to the commencement of their internship, the incoming intern group receives instruction on five consecutive days. In the first place the superintendent and his medical deputy discusses: (1) the rules and regulations of the hospital; (2) hospital records, their importance and their confidential nature; (3) the nomenclature of diseases; (4) the necessity of morning and evening rounds; (5) local laws pertaining to contagious diseases; (6) rules respecting coroners' cases; (7) the importance of autopsies; (8) the question of gratuities and ethics in general; (9) courtesy.

The new interns are greeted by the chairman of the medical staff, who introduces them to the various staff members. The deputy medical superintendent outlines the nature

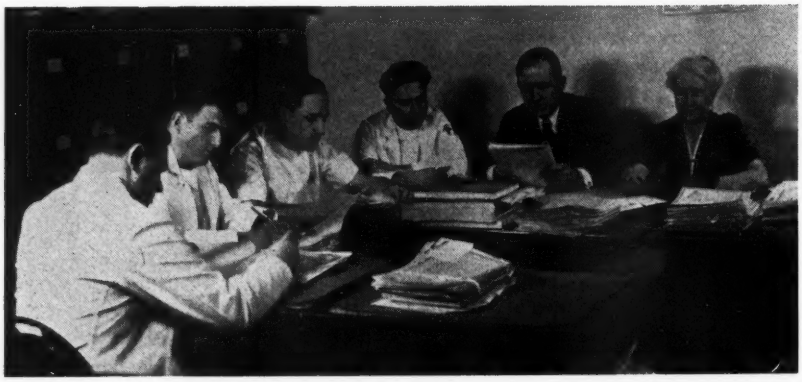
1. *(Above) At an initial conference the superintendent and his assistant explain the rules of the hospital and the schedule of rotation.*



2. *(Left) Two days before commencing his duties the new intern is given a complete physical examination, including X-ray examination of the chest, complete blood-count, urinalysis and other indicated laboratory work.*



3. *(Right) Nursing supervisors explain and demonstrate to the new interns a number of nursing procedures so that they will be familiar with the techniques required.*



4. *The record committee chairman of the medical board with the assistance of the record librarian instructs the new interns in the use of the standard nomenclature. He explains what constitutes a proper history, physical examination, summary, progress notes and discharge notes.*

5. *Before coming on duty the incoming interns have demonstrated to them an abdominal tap, a chest tap and a spinal puncture. Emphasis is laid on the indications and on the necessary equipment required.*

6. *The chief dietitian explains to the new interns the food service and the ways in which the dietary department endeavours to meet the dietary needs of each patient. The importance of dietary correction is emphasized. A general diet should be prescribed unless special diet is indicated, and the interns are requested to send down the diagnosis when ordering a special diet.*

of the internship and explains the various forms that are to be used. The hospital manual, the "bible" is presented.

The superintendent of nurses then greets the new interns with a discussion on nursing matters. The importance of good nursing is emphasized.

The interns are taken on a tour of the hospital, to become acquainted with its various divisions and their functions—the kitchens, laundry, power-house, stores, etc.

The chief dietitian reviews dietetics in health and disease. It is pointed out that patients should be put on a general diet where possible, and that where special diets are indicated the diagnosis should be sent in.

The importance of the social service department and the work which it is doing is explained.

Medical Check-up

Two days before beginning their internship, the new members of the house staff are given a complete physical examination, including X-ray study and laboratory work. Complete records are kept, and the examination is repeated annually. On the following day they are assigned to their rooms and services and given their uniforms.

Demonstration of Common Clinical Procedures

As soon as possible the interns are given a demonstration of infusion technique, of abdominal and chest taps and spinal punctures, of the use of the oxygen tent, the mechanical respirator, the duodenal drainage tube and tube feeding in peptic ulcer. The operation of the blood-bank is explained and instructions are given on the obtaining and giving of blood.

Before being assigned to the operating room the interns become familiar with the instrument tray. They are taught proper scrub technique, the putting on and changing of gloves, the rules of the operating room, the arrangement of the suture tray and the care of instruments.

Emergencies

The handling of emergencies is taught. The intern is also given instruction on the importance of consent signatures, of proper procedure in coroners' cases and the reporting of contagious diseases. An emergency tracheotomy is demonstrated

7.
(Top left) As soon as possible the new interns are taught the use of various kinds of apparatus, such as gas anaesthesia machines, the Drinker Respirator, the oxygen tent, the tracheotomy tube, the basal metabolism machine, etc.

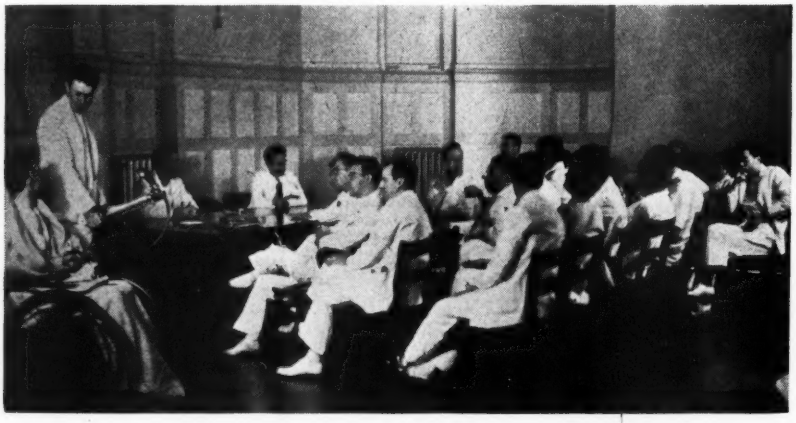
8.
(Top right) The intern's history, physical examination and diagnosis are checked by the resident and then by the visiting physician, who makes corrections and further observations. The intern writes his own progress notes and records the condition on discharge.

9.
(Centre) The intern is expected to follow up the blood, urine and pathological specimens of assigned cases. Periodically the pathologist demonstrates to the interns.

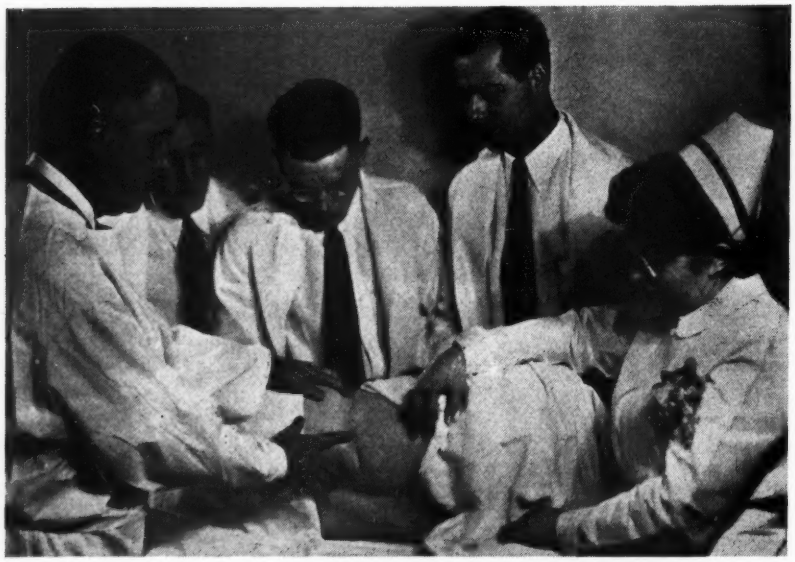
10.
(Lower Left) Prior to assuming duties in the operating room, the interns are taught how to scrub, how to put on uniform and gloves and how to change gloves. They are also taught the rules of the operating room, the rules governing spectators and the care of instruments.

11.
(Lower Right) The interns are encouraged to use the library to the fullest possible extent. A journal club is advocated.

12.
Practical lectures are given by the staff on forty Wednesday afternoons during the year. Lectures are frequently given by visiting doctors. Topics are chosen by the interns.



13.
Junior conferences and journal clubs for the interns alone promote independent work, encourage the scientific spirit and teach the intern to speak and think on his feet.



14.
The importance of follow-up work is impressed upon the intern by having him attend the follow-up clinics.

in the morgue. Every opportunity is given the intern to become familiar with the use of the ophthalmoscope and the auroscope. First-aid treatment for fractures is demonstrated and the contents of the ambulance bag are checked over. He is also taught how to care for alcoholics.

He is expected to follow closely the laboratory work on his own patients. The interpretation of electro-cardiograms is demonstrated, and the radiologist demonstrates X-ray films on frequent occasions.

Nursing Procedures

The intern is taught such nursing procedures as the making and giving of enemas, the administration of hot and cold packs, hypodermoclysis, mustard plasters, methods of restraint, the croup tent, turpentine stupes, irrigation and the care and prevention of bed sores. The usual nursing bed care—alcohol rubs, massage, keeping the foundation sheet taut, and the use of pads, air rings, etc., are taught.

Clinical Teaching

By relating his own diagnosis and then having it checked, the intern is encouraged to think for himself. The visiting physician carefully checks his work, calling attention to errors and supplying additional information and suggestions. The intern is encouraged to meet the relatives. Practical lectures are given on forty Wednesday afternoons during the year. Not only does the intern work with his seniors in bedside work and in routine ward rounds, but he is encouraged to present reviews of histories, diagnoses and treatment at the weekly conference of the medical staff. The interns are encouraged also to have their own independent junior conferences and journal clubs where they present cases to each other and debate various forms of treatment. These conferences are arranged by the educational committee of the house staff. In this hospital the interns meet in the library one afternoon a week to review the current medical literature.

Work in the out-patient department is stressed as being exceedingly helpful for office practice in later years.

New Developments in Training of Volunteer Nursing Aids

Need for Recognition of Several Types of Volunteers

WITHIN the past few weeks conferences, both in the east and in the west, have paved the way for further developments in clarifying the position and training of the volunteer in the nursing field. Considerable progress was made in this direction at a meeting of the executive committee of the Canadian Nurses Association in Vancouver towards the end of January.

Model Curriculum

Many months ago at a conference between representatives of the C.N.A., the Canadian Red Cross Society, the St. John Ambulance Association and the Canadian Hospital Council, arrangements were made for the setting up of a model curriculum for the training in hospitals of volunteers who had already taken the preliminary training in home nursing and first aid under the auspices of either the Red Cross or the St. John Ambulance Association. Experimental courses were set up at Montreal General Hospital and the Royal Victoria Hospital, Montreal for the training of young women who could give practically their full time to the course and who were taking the training, not with the idea of going overseas or even of serving in hospitals in Canada, but with the idea of being prepared to do nursing of any kind in case of an emergency, attack or epidemic, either in their own community or in one to which they would be sent. These courses followed a model curriculum, details of which are outlined in the booklet on the hospital training course for nursing auxiliary members of the Canadian Red Cross Corps.

The Working-Girl Volunteer

Since then there has been a demand for a less extensive syllabus of training for working girls and women who could not devote so much time to training, but who would be able to take some hospital training, over week-ends, during evenings and at other times. This has been associated also with the desire on the part of both individuals and hospitals to have training made available for the position of "ward aides". Whereas the training initially outlined was not primarily for service in hospitals at all, this training now proposed would be for work in hospitals under the supervision of trained nurses, and designed to relieve the short-handed nursing staff of many of the less skilled nursing duties. These women would be expected to work in the hospital where trained or in another designated in case of need.

At the present time in several provinces active steps are being taken under the Civilian Defence Committee (also known as the Civilian Protection Committee) set-up to enroll women in various activities, including nursing. For such volunteers a less intensive course is advocated, and it is understood that the Canadian Red Cross Society has agreed that hospitals should, for the present at least, give requests for such training precedence over arrangements for the more extensive course. There is a possibility that the Red Cross Society may also sponsor this shorter course.

In January the Toronto Hospital Council discussed the advisability of recommending the drawing up of a curriculum for the training of these ward aides and helpers, and passed a resolution to that effect. The Registered Nurses' Association of Ontario has considered this matter and it is understood that suggestions for a modified curriculum for the training of ward aides, etc., has been passed on to the C.N.A.

The executive of the C.N.A. met in Vancouver late in January. It was noted that the problems in each province varied, or were being handled differently, and that a type of training different from that originally planned is obviously being desired in various parts of the country. The advisability of drawing up a less elaborate scheme of practical experience for part-time voluntary workers was referred to the Syllabus Committee and the National Voluntary War Services Advisory Committee, with the suggestion that a conference be called of all organizations interested in the question of auxiliary nursing services.

Uniform Terminology Urged

It was further recommended that all organizations dealing with voluntary workers should adopt common names and classifications for all voluntary workers. This is particularly desirable in view of the great confusion existing in the terminology of nursing volunteers.

The several groups of volunteers should be designated by distinctive terms:

1. There is a group of young women who have taken the extensive curriculum above mentioned, who have had the preliminary training in first aid and home nursing, who could be available full time on demand, and who would be sufficiently mobile to go to any community where needed.

2. Women who could give shorter and probably intermittent periods for practical training in hospitals and would be available only in the case of a local epidemic or disaster. They also should have had the preliminary home nursing and first aid courses.

3. Volunteers with first aid and

(*Continued on page* 48)

New Regulations Respecting Radio Interference by Electrical Equipment Now in Force

THE Controller of Radio of the Department of Transport has issued further instructions with respect to the suppression of inductive interference from electro-medical apparatus. It will be recalled that the Radio Division has had this question of interference under consideration for several years, and the outbreak of war, with the resultant increasing importance of radio communications, has necessitated the rigid enforcement of these new regulations. The Department of Transport has issued Circular S 11-13-25, which reviews this whole subject and which is broader in its scope than the previously issued S 11-13-15 which relates to spark-gap electro-medical apparatus. It is made clear that departmental inspectors will be pleased to offer advice regarding satisfactory and economical means of suppression. Individual consideration will be given to any institution where special treatment would seem required.

Spark-gap Apparatus Interference

Interference from spark-gap electro-medical apparatus, including diathermy apparatus, mechanical rectifiers for X-ray installations and Violet-ray equipment has been under control since January 1st, 1942.

The department came to the conclusion after prolonged observation that filters alone would seldom suppress interference; complete shielding of the room together with a suitable surge trap in the supply lines has been found necessary.

For the present, the regulations in Canada will not apply to short-wave therapy installations, unless they seriously interfere with some vital radio communication. It is not unlikely, however, that they will ultimately be extended to include this equipment as well. It has been suggested that specially designed apparatus of this type might be permitted to operate in a restricted frequency band, thereby obviating the necessity of shielding, but the indications are that such special equipment will not be available for several years, if at all. It has been pointed out too, that, should the development of a suitable machine prove to be technically feasible, its cost is likely to be considerably above the present average—the difference possibly being in excess of the outlay for shielding a moderately sized room.

Tube-type Therapeutic Generators

It has been decided that "interference from radio frequency generators not used for communication, including tube-type diathermy machines, induction furnaces, etc., will be brought under control as soon after January 1st, 1944, (Yes, 1944 Ed.) as metal for shielding becomes available without diverting supplies from more urgent requirements for the war effort. The exact date of this control cannot now be fixed but—it has been decided to control the interference along the following general lines . . ."

When these additional restrictions are put into effect all radiations from non-communication generators (with certain exceptions) will be prohibited except on certain allotted frequencies.

It is not economically feasible to convert the present type of diathermy generators so that they will operate satisfactorily on the desired frequency. It will probably be over a year before therapeutic generators having the desired frequency stability will be available commercially. It is estimated that the cost of such generators may be considerably greater than apparatus now in use. It therefore appears probable that the most economical and satisfactory method of suppressing interference from the therapeutic generators is by operating the same within a thoroughly shielded room having filters in the power supply for the suppression of interference from tube-type generators.

Special Cases

Special consideration will be given to certain institutions.

(a) Many modern hospitals and medical offices buildings. Many modern buildings are so constructed as to form a natural shield, and the power supply fed underground forms an effective filter, so that apparatus operated within the building causes no appreciable interference to receivers remote from the building. Where a radio receiver within such premises is adversely affected, an endeavour should be made by all parties concerned to reduce the interference in the most economical and satisfactory way. Such means may be applied either to the receiving installation or to the interfering apparatus. Noise-reducing antennae are frequently useful in such circumstances.

(b) Temporary exceptions may be made when apparatus is operated where it is probable that no interference (exceeding tolerable limits) is produced to radio receiving stations, but if a complaint of interference be later received, the situation should be immediately reviewed.

(c) When interfering electro-medical apparatus is operated in districts where the noise level from uncontrollable sources is exceptionally high, it will not be necessary, for the present, to suppress the interference from such equipment to a point where further suppression would not benefit the operation of the radio receivers concerned. If, however, spark-gap electro-medical apparatus should detrimentally affect reception, at times when the interference from uncontrollable sources is at a low level, it will be necessary to apply the necessary suppression.

(d) Interference caused by the operation of interfering apparatus in cases of emergency is dealt with under Section 4 of the Regulations for Controlling Radio Interference. This privilege of emergency operation should not be abused. Cases

Hospital Administrator Selected as Hamilton's Outstanding Citizen

The outstanding citizen of the city of Hamilton for 1941 was Dr. J. Howard Holbrook, superintendent of the Mountain Sanatorium. This decision was reached by an independent board of judges representing all classes of citizens. This committee was charged with the selection of the individual who had done "the greatest good for the greater number".

The award of the plaque and the gold medal was made at the annual "Civic Night" dinner meeting of the Hamilton Advertising and Sales Club. The judges' decision was announced by W. H. Lovering, chairman of the Hamilton Health Association, who spoke very eulogistically of the work of his close associate, and the award was made by Mayor William Morrison.

Dr. Holbrook has had a long career in the health field, and over a period of 30 years has built up the Mountain Sanatorium from its beginnings in a private house to its present position as one of the great institutions on this continent. Dr. Holbrook is a past-president of the Ontario Hospital Association and has for many years been one of its board of directors. He is also past-president of the Ontario Medical Association, and at the present time is president of the Canadian Tuberculosis Association. For the past four years Dr. Holbrook has been chairman of the Committee on Health Insurance of the Canadian Hospital Council.

To. Dr. Holbrook we extend our congratulations on his receipt of this well-deserved recognition and honour.

Dr. J. H. Holbrook Receives Gold Medal

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involving the use of electro-medical apparatus for patients who cannot be moved to a shielded room or otherwise given the desired treatment without causing interference should be classed as emergencies. The use of Violet-ray and diathermy apparatus in private homes, hospital wards, beauty parlours or barber shops, and in all cases where the patient can safely be moved to a shielded room, should not be considered cases of emergency. Hospitals in the habit of using interfering equipment in the ordinary wards should be provided with a shielded room or other means of suppressing the interference, in order that no interference may be caused by the treatment of patients whose conditions would permit them to be moved with safety.

Interference from rectifiers of X-ray apparatus used only for radiography and interfering apparatus necessary for surgery, operated occasionally for periods of a few seconds, will not require suppression at the present time, provided it does not interfere with vital communications. The exact time limits have not yet been determined.

Where there has been difficulty in obtaining materials or labour to instal suppression of interference equipment, users of interfering equipment of the spark-gap type may apply to the nearest Radio Inspector of the Department of Transport for permission to operate their apparatus until such time as the necessary suppression can be effected, provided that they submit proof with the application that they have made a reasonable effort to suppress the interference and that the interference will be suppressed as soon as possible. Such proof should contain sufficient detail to enable the radio inspectors to assist in hastening the completion of the suppression by advising where the desired material can be obtained or recommending suitable substitutes.

Hospitals Receive Sugar Concession

The new regulation, Order No. 93, respecting the rationing of sugar, announced on January 26th, states in Section 7:

"7. The Sugar Administrator shall have power to grant exemptions or permits or otherwise regulate and control the use of sugar by hospitals and other public institutions, and in special cases of individual hardship, and in such other cases as he may deem proper."

This wording is somewhat different from the public notice, released January 29, 1942, to the effect that:

> "Residential establishments and institutions must observe the terms of the general consumer rationing, namely, three quarters of a pound per person per week."

Among "residential establishments" are listed *nursing homes.* Among "institutions" are listed *hospitals, sanatoria, convalescent homes, orphanages, infirmaries, monasteries* and *nunneries* and *asylums.* It is further added in keeping with the section of the Order quoted above that:

> "The rationing provisions may be relaxed in relation to patients in such institutions wherever it is considered advisable for medical reasons."

The Sugar Administrator is Mr. S. R. Noble.

Storage and Handling of Gases

The following article constitutes Section 5 of a report on "Recommended Safe Practice for the Use of Combustible Anaesthetics in Hospital Operating Rooms". This report was presented at the meeting last year in Toronto of the National Fire Protection Association, and was tentatively adopted at that meeting. The conference committee represented a large number of national associations interested in fire protection, and included Dr. W. P. Morrill of the American Hospital Association and Dr. M. T. MacEachern of the American College of Surgeons. The chairman was Professor J. Warren Horton of the Massachusetts Institute of Technology.

It is proposed in our next issue to review the chapter on "The Reduction of Electrostatic Hazard". Complete copies of the report are available at the international office of the National Fire Protection Association, 60 Batterymarch Street, Boston. Price 15 cents.

THE recommendations presented here are, in general, taken from previously published good practice requirements and safety codes. They have been modified, where necessary, to bring the several sources into agreement with each other and with other sections of these recommendations. They include and are in conformity with the recommended good practice requirements adopted by the National Fire Protection Association and by the National Board of Fire Underwriters and with the recommendations of the National Safety Council and of the American Hospital Association.

Specifications for Cylinders

All cylinders containing compressed gases, such as anaesthetic gases, oxygen, or other gases used for medicinal purposes, whether these gases be flammable or not, should be in accordance with the regulations of the Interstate Commerce Commission with respect to construction, testing and fittings.

Marking of Cylinders

All cylinders containing compressed gases should be clearly marked with the name of the gas contained therein.

All cylinders containing compressed gases should, in addition to showing the name of the gas, show conspicuously a colour indicating the nature of the gas contained therein. Recommendations and regulations of the Interstate Commerce Commission and of the National Bureau of Standards regarding suitable conventions for such colour coding should be followed.

Storage of Containers

All cylinders containing compressed gases, and all cans containing volatile liquids should be stored in dry locations ventilated as recommended in Section IV. Under no circumstances should these cylinders be stored in the operating room. If stored in an adjoining room there should be a blank wall between such room and the operating room. In all cases the storage of compressed gases and of flammable liquids should be in strict accordance with the provisions of State law and of municipal ordinances.

Location of Containers

Cylinders containing compressed gases, or cans containing volatile liquids should be kept away from radiators, steam pipes, and like sources of heat. Cylinders containing reducing gases, such as ethylene or cyclopropane, and cans containing flammable liquids, such as ether, should be kept out of proximity to cylinders containing oxidizing gases, such as oxygen or nitrous oxide. Flammable materials, such as wood and fabrics, should not be stored or kept near cylinders containing oxygen.

Coverings

Cylinders containing compressed gases, cans containing volatile liquids, and anaesthetic administering equipment not in active use should never be covered with fabric or other covering at any time.

Special Care of Oxygen Cylinders

Great care must be exercised with cylinders containing compressed oxygen to prevent any accumulation of grease or oil on either the cylinder or any of the fittings attached thereto. Such cylinders and fittings should never be wiped or rubbed with any cloth, waste, or similar material likely to contain oil or grease.

Regulators and Valves

Suitable approved regulators or other gas flow control devices should be used in conjunction with any cylinder containing gas used for medicinal purposes.

Cylinder Connections

No equipment should be used for coupling cylinders containing compressed gases which might permit the inter-mixing of gases, either through defects in the mechanism or through error in manipulation, in any portion of the high pressure side of any system in which these gases may flow. It is particularly important that the intermixing of oxidizing and reducing gases under pressure be scrupulously avoided as such mixing inevitably results in spontaneous combustion and explosions of terrific violence.

Filling of Cylinders

Compressed gas should never be transferred from one storage cylinder to another on the hospital premises.

Piping Systems for Gases

Systems for the distribution of gases should, except as noted below, employ standard, full weight iron-pipe-size brass pipe with substantial brass fittings, or approved seamless drawn well annealed copper, brass, or other non-ferrous tubing with approved fittings, protected against mechanical injury in a manner satisfactory to the authorities having jurisdiction. In all piping systems proper allowance should be made for expansion and contraction, jarring and vibration. Brass used for such piping should have a copper content of not less than 83 per

cent. Long runs of piping should be avoided and cylinders should be located as close as feasible to points of consumption.

An exception may be made in the case of nitrous oxide, for the distribution of which iron or steel tubing may be used.

An exception should be made in the case of ethylene, for the distribution of which iron or steel tubing should be used.

Where threaded joints or fittings are used threads should be in accordance with the American Pipe Thread Standard. All joints should be sweated with solder.

Where anaesthetic or other gases used for medicinal purposes are piped from building to building, pipes should preferably be placed in a separate tile duct used for no other purpose. If tunnels containing other piping are used for this purpose the anaesthetic or other gases should be segregated in a special basket type metal duct for this use exclusively, having screened sides, top and bottom, and conspicuously labeled at frequent intervals "DANGEROUS GASES". Such tunnels should be well lighted and ventilated.

All piping should be tested and proven tight at one and one half times the maximum working pressure, but never at less than 100 pounds per square inch. Before being placed in service such piping should be thoroughly blown out to insure freedom from foreign materials.

Identification of Pipe Lines

All oxygen pipe lines should be painted one colour, preferably green, and all anaesthetic gas lines a different colour. Where more than one anaesthetic gas is piped, the lines distributing the different anaesthetics should be painted distinctive colours.

A chart identifying the various gases according to colours employed should be prominently displayed.

Manifolding Anaesthetic Cylinders to Headers

Headers should be constructed of double extra heavy piping, preferably brass or bronze, not exceeding one and one quarter inch nominal pipe size. Fittings in header, if used, should be extra heavy. Headers should be provided with shut-off valves at each point where a cylinder is to be connected.

Leads from header valves to cylinder valves should be constructed of steel tubing or an approved composition pipe, and should be capable of withstanding a pressure of 1000 pounds per square inch.

The discharge opening from the header should be equipped with an approved regulator.

Manifold systems should be capable of withstanding a test pressure of one and one half times the charging pressure.

A preferred arrangement from the safety standpoint is to so set the manifold regulators that when one side of the manifold is exhausted, the other side will automatically function.

A method which eliminates the need of a header and which has been successfully used in practice, is to connect two cylinders to the piping system and so set the regulator of the second cylinder that when the first is empty, the second cylinder will automatically come into service.

Oxygen Manifolds

Oxygen manifolds or headers should be constructed of bronze of such weight as to insure suitability for the purpose. All section of the header should be freed of foreign material and combustible matter before assembly.

Fittings for header should be of substantial design and may be threaded and soldered to header or threaded using litharge and glycerine only.

The leads or connections attaching cylinders to header should be constructed of annealed brass, bronze or copper, of suitable strength.

High pressure headers, fittings and leads should be capable of withstanding a pressure of 3600 pounds per square inch.

Headers, fittings and leads after assembly should be washed out with carbon tetrachloride or other suitable grease solvent and blown out by low pressure oxygen.

It is recommended that oxygen headers or manifolds be purchased from, and installed by, reliable manufacturers familiar with the proper shop practice with reference to their construction and installation.

Emergency Shut-off Valves

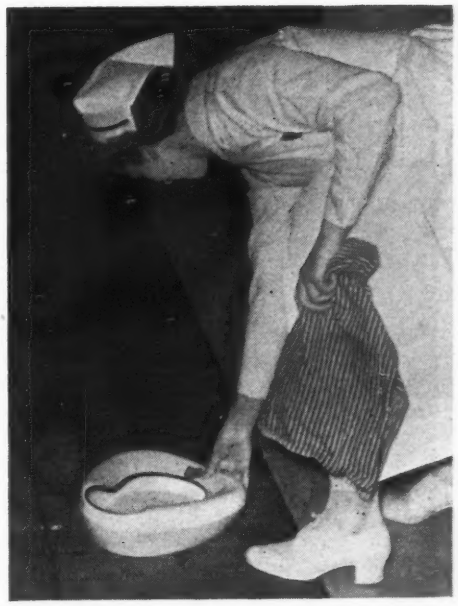
In addition to the shut-off valves within the operating room, a shut-off valve should be provided outside

(*Continued on page 44*)

Noise Disturbance in Hospitals

A Series

3. The Clatter of Falling Objects



The increased use of terrazo, tile and other hard flooring has made the clatter of falling articles particularly disturbing. Many objects such as bedpans, urinals and pus basins slip from the fingers very readily. Carelessly piled dishes on trays frequently fall to their ruin. The placing of utility room entrances around corners, a self-closing device on the door, corridor doors, acoustical treatment and, above all, constant vigilance of nurses, orderlies, doctors and maids can markedly reduce this disturbance.

With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor,

An editorial note to an article in your July issue, recording a tour of the London Voluntary Hospitals, pointed out that it did not include any reference to the hospitals of the London County Council. In fact for various reasons no narrative has been published about this remarkable chapter in the history of hospitals. Nevertheless unpublished information has been freely placed at my disposal in order that I may make an attempt to give your readers some idea of the extent of the damage done to them by aerial attacks.

There is some advantage in surveying the situation during the lull as it is possible to do so with a calm uninfluenced by the emotion experienced while raids are in progress.

The London County Council is responsible for hospitals for mental and infectious diseases as well as the hospitals for general and medical cases of all kinds. In all there are ninety-eight hospitals. Some are in rural areas well away from London, but ninety-four hospitals, including all within the County of London, have suffered in greater or less degree from the breaking of windows and minor damage to the complete destruction of blocks. Not one has escaped. Will any reader just let his imagination dwell on what that would mean if it were his own hospital. Obviously just to give an adequate record of the loss of life and the material damage would completely fill several numbers of THE CANADIAN HOSPITAL and then a special issue in letters of gold would be required for the news of heroism, unswerving devotion to duty and steady work, regardless of what was happening around, on the part of all ranks of the staff.

Therefore, all that I can do is to give examples; to avoid any invidious discrimination I take two quite close to my own residence. In order to maintain the perspective let me preface the particulars by saying that the hospital to which I should be taken as a casualty has suffered only slight damage. Incidentally may I interpolate that although I am a member of the committee of a voluntary hospital within a quarter of an hour's walk of my home, it would be to a hospital of the L.C.C. that I should be taken as an air raid casualty. In normal times if I were suffering from scarlet fever, or any of the infectious diseases, I should go to a hospital which has had thirteen direct hits with high explosive bombs. In addition some one hundred and sixty incendiary bombs were scattered over the buildings

What the War Has Done To 94 of the 98 London County Council Hospitals

occupying eleven acres. The normal bed complement of the hospital is 484 and as it stands in a danger area it was reduced to 200 for casualties and 90 for fevers. At the time of my visit the debris had been cleared up and nothing but a great gap in the main building represents the portion formerly occupied by the medical superintendent, the matron and steward, with rooms above for the nurses. In spite of all these attacks, not a single patient has been either killed or injured although on one occasion the building into which casualties had been received was hit, and in it four nurses were killed and thirteen injured. It was on this occasion that a porter, Albert Dolphin, was killed and was awarded posthumously the George Cross, the highest in the new Order for Valour by civilians. The official record simply states:

Porter Dolphin gave his life for a seventeen year old probationer nurse who was trapped under wreckage that had fallen on her. When it was apparent that further masonry was about to fall, Dolphin with disregard for his own safety, fell across the body of the probationer nurse and gave her protection, thereby saving her life.

Nothing has been more remarkable than the way in which the staffs of the Steward's and Work's Departments have risen to the enormous demands upon them in these hours of danger and strain. Whether it obtains recognition depends very often upon a number of fortuitous circumstances, so that these awards can only be regarded as representative rather than comprehensive in any degree. Lord Chatfield and his committee have devoted unlimited care to their undertaking of making the recommendations to the King, but they must be dependent upon the people in the institutions and from those in the localities for their enlightenment. Even those who do not have the opportunity to show it possess the same braveness of spirit.

The other hospital in my neighbourhood which may be given as an example is normally a large general hospital with more than eight hundred beds. It has wards specially for pulmonary tuberculosis and a fine ante-natal and maternity department. In one of the attacks a high explosive bomb fell in a subway and had a most extraordinary range of damage. The main corridor of the hospital with six inches of cement was blown up in several directions with the result that heating and water services, lifts and gas mains were put out of action. A block of administrative quarters was demolished. On this occasion three porters were killed, and the injured were four sisters, one deputy sister, two probationer nurses and two clerks. This hospital provided another example of the incomprehensible action of these explosives. The boiler house was completely destroyed and yet the large chimney arising in the middle appears still to be standing safe. It illustrates conflicting views about the skill and mentality of the attacking air forces. It is argued that these big factory-like chimneys standing in the midst of uniformly laid out

buildings may give them the appearance from the air of being munition factories. If it be admitted that the airmen thus regard them as legitimate targets then it must also be admitted that the aim has frequently been accurate. An impartial judgement seems to be that a great deal of the bombing is quite indiscriminate.

The total number of patients killed in all the raids has been two hundred and of that number eighty-six were in one hospital standing in a much devastated part of London. This number may seem surprisingly small but the way in which people have escaped in spite of all the conditions has been nothing short of miraculous. At the same time it was thought wise to close this particular hospital owing to the possible psychological effect upon patients. Three medical officers, thirty-one nurses and ten porters in the Council's service have lost their lives. Two of the doctors were killed in the May raid when the Resident Doctor's quarters, the main theatre and kitchen of one hospital were demolished with the result that it has not been re-opened yet.

In spite of all the efforts to continue the work, time after time the damage has been so serious as to compel a stoppage. The "incidents" as boldly stated in the official reports show the variety. (1) Boiler house demolished. Hospital evacuated for three weeks. (2) Part of the main kitchen demolished — accommodation reduced by four hundred beds owing to lack of cooking facilities for one month. On another occasion two hundred and eleven more beds were closed, two months later two hundred and thirty-nine and in the following month a whole block was demolished. (3) Hospital evacuated for six weeks. (4) Hospital evacuated. And so the record continues and shows that one after another have simply had some portion "knocked out," some permanently and others for long periods. The total number of beds put out of commission is 14,626, being 9,543 in general hospitals, 3,420 in special hospitals and 1,663 in mental hospitals. Approximately 5,041 of these beds have been destroyed or the accommodation so damaged that it cannot be restored until after the war. Since the raids started 8,123 beds have been recommissioned, so that at the time of writing 6,503 are still out of commission. These bald facts give no idea of the innumerable practical difficulties involved in trying to carry on the work. When the windows and the black-out arrangements are blown out it is impossible to have any lights to see how to attend to the patients. Patients have to be evacuated at short notice, staff distributed and the premises cleared up as soon as possible. Throughout there always lies the main fact that the Council hospital has the responsibility for maintaining the ordinary, as well as making its contribution to the casualty service. The voluntary hospital can pass on the patients without failing in any duty imposed by authority. The Council hospital cannot do so and is proud of its record that it never fails in its duty to its constituents.

Photo by W. E. King, London S. E. 14

A nurse received the George Cross for Valour when this L.C.C. hospital was destroyed.

THE FIXING OF ROOM CHARGES

Negotiations between the Canadian Hospital Council and the Wartime Prices and Trade Board respecting the fixing of hospital room rates are continuing. It is possible that a further announcement will be in order shortly, but the question of a fixed ceiling involves interpretations of rulings respecting consumers' prices, rentals, the right to obtain the benefit of subsidized prices and other factors. This has necessitated further conferences between the various control divisions involved.

Until further announcement be made, hospitals should leave their room rates as of the period September 15—October 11, 1941. Charges for extras may be increased if necessary. The Canadian Hospital Council will continue to notify the secretaries of provincial and regional associations directly, whenever rulings of vital importance are announced.

You Can Defend Them

The Battle Against Venereal Diseases

DONALD H. WILLIAMS, M.D.
Director, Venereal Diseases Branch,
British Columbia Board of Health.

In view of the recent publicity resulting from Surgeon-General Parran's statements respecting venereal disease and American soldiers and the five million dollar W.P.A. appropriation to combat venereal disease, this (condensed) statement by an eminent Canadian authority will be of significance. (Ed.)

AHEAD of us lie days of national danger, days when free democracies are literally fighting for existence. Two major tasks confront the people. One is to make the nation so strong that attacks from without may be resisted—and with this necessity none will disagree. The other is to expose and disarm all the internal enemies which seek to undermine national strength and efficiency.

It is a fact that while the activities of fifth-columnist and foreign agents have received wide attention and inspired demands that these subversive forces be suppressed, the most destructive agents within a country are not the ones who are paid by foreign governments. The agent which causes the greatest havoc and does most to undermine the efficiency of a nation is disease—all serious diseases in general and the venereal diseases in particular. It is the purpose of the British Columbia Board of Health on behalf of a more efficient national defence effort to give you certain facts concerning diseases which form a "fifth column" in our midst. Those two diseases are syphilis and gonorrhoea. The critical days of national emergency require that every citizen in our free democracy make it his duty to assist in reducing the menace of venereal disease. We know that the control of syphilis and gonorrhoea is not entirely a medical problem. It is also an economic problem, a social problem, an educational problem; it is a problem so deeply rooted in our society that the co-operation of every citizen is needed to solve it.

The measures necessary to control syphilis and gonorrhoea are well-known, and they have been tested. The British Columbia Board of Health is not referring to theories or Utopian dreams. It is referring to the brilliant accomplishments of the Scandinavian countries during the past thirty years. With enthusiastic acclaim health authorities throughout the world point to the reduction of syphilis in these countries to almost a vanishing point.

What are the measures which have so effectively controlled venereal disease in the Scandinavian countries? They are three—education, social and economic improvement and law enforcement. Before them the barrier of prudery, defeatism and the vested interest of commercialized prostitution has crumbled. To-day this barrier is crumbling in this country. The "conspiracy of silence" that has enveloped the subject of venereal disease has been broken. Every citizen may now know the facts and by this knowledge he suddenly will see revealed the sordid, mercenary business of commercialized prostitution as a community fester from whose rankness spreads venereal disease, suffering and death.

Commercialized prostitution, in the words of Abraham Flexner, "is everywhere purely mercenary, everywhere rapacious, everywhere perverse, diseased, sordid, vulgar and almost always filthy." Commercialized prostitution is the illegal exploitation of venereally-diseased young women in bawdy houses. It is purely a mercenary business intimately associated with the criminal elements of society. The more evident exploiters are madames, pimps and procurers. The profits emanating from this illegal business, however, do not stop with these exploiters. The soiled monetary streams in their diverse ramifications reach certain persons so remote that their participation in the business is only recognized by their indignation when the sources of profits is disturbed by efforts of those interested in stopping this disease-dispensing exploitation.

It is alarming to learn that, in spite of the Criminal Code of Canada and of the voice of public health authority, venereal-disease-riddled, commercialized prostitution continues to flaunt the law and spread infection. This situation can no longer be tolerated. Up to the present time, ignorance of the facts and indifference on the part of citizens have permitted this health menace to continue. Now the expediency of national defence demands that the "fifth column" of commercialized prostitution cease its insidious undermining of our efficiency through the spreading of venereal disease to "the young, the brave, the strong" engaged in essential civilian and military war work. The vigorous enforcement of sections of the Criminal Code directed against the exploiters of diseased prostitutes is essential to maintaining a highly efficient war effort. For many years the bawdy house interests have deliberately spread their subtle and superficially plausible propaganda until in many instances well-meaning citizens in their ignorance of the truth unwittingly have given vocal support to a policy which is undermining public health.

What is this false propaganda of the bawdy house interests? The three principle ones are:—"spreading the professional prostitutes and their disease throughout the city" and "the endangering of the chastity of decent women and young girls by assault and rape" and "the necessity of providing facilities for rehabilitating the prostitutes before putting teeth in the law and closing the houses". The public does not realize that "spreading" is actually beneficial in that it makes access to the sources of disease more difficult.

(*Continued on page* 48)

Political "Baby-Kissers" Scored

Dr. Alan Brown Calls for Enlightened Municipal Leadership

"The child is the best and most lasting asset of the state and his undernutrition or defects either in time of peace or war are unfortunate," stated Dr. Alan Brown, physician-in-chief to the Hospital for Sick Children, in an address to the Welfare Council of Toronto. "The care of children during the war should not differ from that during peace time, provided thorough work was being done.

"The report that 44 per cent of the young men recently called up for military service were not fit for that work, made us realize forcibly that we are a surprisingly unhealthy lot. Young men from 21 to 25 years of age should be at their prime. They should be our healthiest citizens, but the figures show us that many of them are not. Without a doubt, a large proportion of these physical defects would never have occured if in their youth these men had had the right kind of food, reasonably good living quarters and adequate medical supervision and attention."

A Fine Record

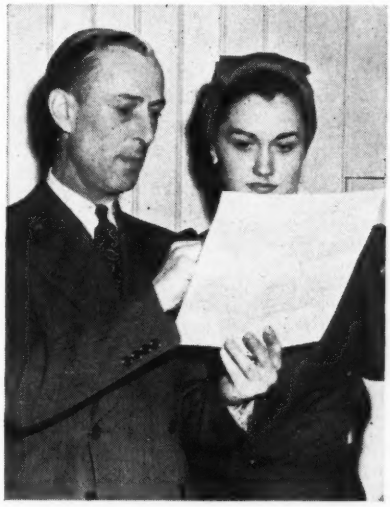
Commenting on the splendid record of Toronto in bringing down its infant mortality rate from 155 per 1,000 births in 1914 to 41 per 1,000 births in 1940, Dr. Brown analyzed the factors promoting this drop. Prematurity had fallen 32% and birth injury was down 62%, indicating improvements in obstetrical care. Diarrhoea and enteritis among infants came down 92% and influenza and pneumonia 47%. The mortality rate in the neo-natal period, that is under one month of age, had decreased 33%.

The understaffing of the local Health Department was scored. This made it quite impossible for the Health Department, although properly organized, to extend and take advantage of the new life-saving discoveries of modern scientific medicine. "This is because their budget, instead of increasing to keep pace with modern advances, has been reduced at the instigation of 'political baby-kissers'. This is largely due to the fact that the people who control the city finances do not appreciate what great good could be accomplished by increased public health services." A minimum of $2.50 per capita should be expended on the municipal Health Department, Dr. Brown declared. "Besides being more humane, it is so much cheaper for the whole cummunity to prevent rather than to treat disease. It has been estimated that the discovery of an early case of tuberculosis saves the taxpayer $2,000. A public health physician wouldn't have to find many such cases to earn his salary! The fact is that tuberculosis could be wiped out in one decade if all the known health and social measures were adequately applied."

Recommendations

The following recommendations were stressed:

1. More public health physicians, nurses and laboratory workers. It is calculated that the ideal situation is one public health nurse for each 350 to 400 children.
2. A paediatrician for the correlation of this work and co-operation with the health officer.
3. A nutrition worker on the staff of the health department.
4. A campaign to reduce premature mortality.
5. A service for the early diagnosis of whooping cough.
6. More prenatal clinics.
7. Re-opening of the pre-school clinics, and the encouragement of the mothers to bring their children to them. For this is needed the appointment of adequate doctors to administer these services.
8. Expansion of the medical and dental services in the elementary schools.
9. Physical examination and health instruction for children in the secondary schools.



Ontario Plan for Hospital Care Passes 50,000 Mark

Miss Mary A. Parsons, a Bren gun munitions worker—and an attractive one, too—had the honour of being the 50,000th member of the Plan for Hospital Care in Ontario. This plan, despite the handicaps of the heavy N.D. Tax, the unemployment insurance levies and other wage deductions, has made rapid progress and has paved the way for a considerable expansion in the near future.

The staff has been enlarged considerably, larger quarters have been taken on the eighth floor of the Excelsior Life Building in Toronto and, it is announced by Mr. Norman H. Saunders, the Director, preparations have been made for the more rapid inclusion in the Plan of an increasing number of Ontario communities.

In the cut above, Miss Parsons is having her contract explained to her by Mr. P. G. Bell, Manager of the Training School at the John Inglis Company, Toronto.

Payment of Annual Dues by Canadian Members in A.H.A.

Canadian members of the A.H.A. may pay their annual dues in Canadian funds. The Foreign Exchange Control Board at Ottawa has assigned the association Permit No. NS 594, which permits the operation of a Canadian dollar account with the Bank of Montreal. By this means Canadians will not need to make application for a permit to remit dues in Canadian funds to the association.

The amount of the statement covering membership dues may be remitted to Chicago in Canadian dollars without the necessity of making special application, since by this arrangement Canadian funds are accepted at par.

Obiter Dicta

This Question of A.R.P. Cost

WITH the entry of Japan into the war, Canada is now more intimately concerned with the possibility of direct attack, and A.R.P. organization has proceeded with distinct acceleration. On the west coast particularly, all phases of A.R.P. preparation including that for medical care, have been speeded up. In Ontario since December 7th the Federal authorities have extended the localized "vulnerable areas" of the province from the Toronto and Hamilton areas to cover all of Ontario east of and including Sault Ste. Marie. This has required the organization of a large, thickly-populated area and has involved many additional hospitals. In the maritime provinces organization is said to have been fairly complete for some time.

There is still all too much uncertainty concerning the factor of cost. Beyond having a pool of beds and bedding for emergency needs the Federal government takes no responsibility. As far as is known at this office the Provincial governments also disclaim the financial responsibility, leaving it to the municipalities to reimburse the hospitals for their expenditure. The municipalities in turn feel that it is not their responsibility, and most of them have "passed the buck"—back to the hospitals.

Chapter One of the Defence of Canada Regulations states:

"The Minister of National Defence or the Minister of Pensions and National Health may by order prescribe the steps which are to be taken by persons in Canada to protect themselves . . . etc."

The chairman of the Civilian Protection Committee (or Civilian Defence Committee—same thing) is the deputy minister of the Federal Department of Pensions and National Health, and the members are all federal officials. The Federal A.R.P. Committee is made up of representatives of the Federal Government and a representative of the St. John Ambulance Association. All this does seem to spell federal responsibility. Certainly from the hospital viewpoint, the responsibility is either federal or up to the provincial governments from which the hospitals receive their instructions to make these changes.

Some idea of the cost of making even ordinary preparations, altogether apart from providing special accommodation and equipment, is illustrated in a summary of the costs of treating windows and doors in the Toronto and Hamilton areas. Blackout treatment of hospital windows for the hospitals in this area would cost $19,530; the cost to the Toronto General Hospital alone is estimated at $3,774. (The Vancouver General Hospital is spending $8,000 of its own income for blackout alone.) Taping windows to prevent shattering in the Toronto area is estimated to cost $4,889. Treating outside doors, of which there are 468, at an estimated cost of $2.00 a square foot, would cost $37,930. The total cost of protecting the hospitals in these two cities simply for blackout and against concussion, is estimated to amount to $420,585! This would only cover vital services above the first floor, and would not cover the still larger items of providing auxiliary light and water supplies, setting up of emergency operating rooms, etc.

Hospitals realize that it is up to every individual and to every institution to do what it can to protect its own property and to contribute towards the defence of its own community. Hospitals, however, are not only being asked to protect their own property, existing in the first place solely for community benefit, but are also being asked to make additional preparations to receive raid casualties.

In view of the fact that the Controller of Services has ruled that hospitals cannot adjust their room rates to meet increasing costs, hospitals are rightly asking, How can all this be done? It is high time that something be done to definitely clarify the financial responsibility of the Federal Government, the Provincial Governments, the municipalities and the hospitals in defence preparations in both vulnerable and non-vulnerable areas.

An Appreciation

THE Executive of a large luncheon club was striking its standing committees. The Programme Committee was satisfactorily named, then came "Membership".

A publicity man on the Executive made this very trite remark, "You have already appointed your Membership Committee, for if the Programme Committee does its job there is nothing left for the Membership Committee to do except have the names signed on the dotted line".

With our Hospital Journal the Editorial Board is really the pace setter. If the magazine material is good it will attract subscribers, who will attract advertisers, who will increase the Journal's revenues, which will secure more and better material, that will attract more readers, that will—and so on and on.

This last year has been in every way the best in the Journal's history. In spite of many restrictions and

difficulties (that all publications had to face) due to war conditions, it has prospered. It must have met the hospitals' need to do this.

The support of the advertisers has been most gratifying, when it is realized that many of them at the moment are not looking for new business—in fact cannot supply current demands. They are, fortunately, following the British principle, so obvious in the brief but attenuated weeklies that we receive, of keeping their name before the public and getting ready for the after-the-war transition.

This is the long view. The far-sighted ones will not be disappointed in the ultimate return, for hospital memories are long (or should be) and the goodwill engendered when the firms did not need business will be "bread upon the waters" when the post-war competition for the hospitals' purchasing dollar arrives.

G. F. S.

A Dangerous Precedent

A VERY fundamental issue was involved in the recent request of representatives of striking miners at Kirkland Lake that union members taken to hospital would not be classified as indigents should they not be able to meet their hospital bills. In asking the Board of the local hospital, a 144-bed hospital operated by the Red Cross Society, to "carry" union members unable to pay and not consider them as indigents, the union officials promised their "utmost co-operation" in seeing that their members were made aware of their later responsibilities, and assured the Board that their members would be expected to pay their bills when able.

To this request Dr. William S. Caldwell, director of hospitals for the Canadian Red Cross Society, asked the delegation if they appreciated where such a policy would lead the hospital. Because of the strike the hospital Board is already forced to borrow heavily in order to carry on. Although the hospital Board was not desirous of reporting, as indigents, union members who could not pay their accounts, their acceptance without payment would lead to a further deficit which, under the local arrangement, would be charged to the municipality anyway. Chairman Goddard of the hospital Board stated: "If we make exceptions to cover men on strike or their dependents, we must be prepared to make exceptions to cover others of the public who may find themselves in circumstances that prevent their paying for hospital services". The hospital Board regretfully declined to make this concession. It was pointed out that the hospital operates under a Hospital Act which requires that, unless the municipality is notified within 15 days that certain patients are not in a position to pay their accounts, the hospital itself would be required to do so. This the hospital is not in a position to do.

The hospital Board would seem to be on sound ground. If the miners of Kirkland Lake decide to go on strike, particularly at this time, they should not expect that the hospital be made to suffer. Although in other miners' unions, hospital care plans operate to meet hospital costs during strikes as well as working periods, no such provision was made in Kirkland Lake. Nor was the union prepared to guarantee hospital payments. Said Dr. Caldwell: "You are asking this Board, and it is facing financial difficulties, to undertake the responsibility that you yourselves are not prepared to undertake".

It is not our desire to discuss the merits or demerits of this strike. Although it has been in progress now since November 18th, the loss of a fairly substantial part of our gold production has dislocated our national economy far less than had been feared. We are thinking now-a-days in terms of *essential products and services* rather than reserves of currency, and the miners are finding out the hard way that a continual flow of gold for export is by no means as essential as we formerly believed. Moreover, the gravity of the national emergency is such that employer-employee relations are no longer a private matter. It is now recognized that the employer who takes advantage of a surplus of labour to impose conditions favourable to himself and his profits, and, conversely, the employee who capitalizes on a shortage of labour or an emergency, should rightly be the object of public disapproval.

Altogether apart from the possible justification of this strike, repeated reports from the Kirkland Lake area would indicate that many of the miners and their families have made little effort to salt away any of their funds for a rainy day. The time is past when hospitals should permit people who have made no joint or individual reserve for future hospitalization to impose upon long-suffering institutions, really at the expense of other patients and of those who wait upon them. The hospital Board is using good judgement in not allowing itself and other hospitals to be stampeded into a dangerous precedent.

Right to Control Medical Privileges

A CASE is reported in *Hospital Management* in which a court has affirmed the right of the hospital to deny its privileges to a member of the medical profession. While American decisions are not necessarily binding on Canadian courts or customs, there is such a close similarity in the practices followed and the policies recognized that such decision would probably be noted in Canadian courts.

In this case the physician insisted on operating in the hospital in spite of the prohibition of the board of directors and as a matter of fact did perform one operation. The board then asked for an injunction to prevent the physician from operating in its hospital and the injunction was granted.

"The right of the government of the hospital to allow the use of its facilities to members of the medical profession has long been recognized and has been supported by many court decisions, including one by the Supreme Court of the United States. This is, however, the first case that we have heard about in which the governing body took legal action to enforce its decision. In all other cases it has been the physician who was denied the privilege who instituted the proceedings."

Here and There

By THE EDITOR

A Historic Chloroform Party

Sir James Y. Simpson's great contribution to anaesthesia by the use of chloroform for anaesthetic operations in 1847 is well known. But it is not so widely known that his consuming interest as an obstetrician in the alleviation of the pain of child-birth was inspired by the tales told him of the suffering endured by his own mother during his birth. He had experimented with ether, which had recently been tried out in the United States and then by Liston in London, but he quickly found that, for obstetrics, the nausea engendered discouraged its use. Nor was Bromide of Ethyl a success. Then he heard of chloroform, discovered 16 years earlier and used experimentally to produce a slight intoxication and as a remedy for respiratory troubles. At a dinner party attended by two of his colleagues, his wife, her niece and a naval officer, a discussion of his proposed experiment led to a decision to transform the dinner party into a chloroform party.

Here we shall let René Fülöp-Miller tell the story as he did in his excellent book *"Triumph Over Pain"*:

Each of the participants was handed a tumbler containing a modicum of chloroform in the bottom. "Are you ready? asked Simpson. "One, two, three." He clapped his hands, and at the same instant they all began to draw long, deep breaths of cholorform vapour.

The effect was first noticeable in Miss Petrie. Usually a retiring young woman, she displayed ecstasy and excitement; "I'm beginning to fly!" she shouted. "I'm an angel, oh, I'm an angel!" Hardly had she spoken these words when her head dropped forward and she was fast asleep.

At the same moment Dr. Keith burst out laughing. Was it Miss Petrie's ecstatic words which had amused him? No one could tell, but his laughter proved infectious. Dr. Duncan, Mrs. Simpson, the Professor himself, all began to laugh. They felt very happy, became extremely loquacious, shouted loudly and roared with laughter. Only the naval officer sat looking on, puzzled and aloof. He stared at the others' strange antics. "What are you all so excited about?" he was on the point of saying, but hardly had he begun to speak, in a deep bass, when his voice broke into falsetto. Then he began to crow like a cock, which made the others more hilarious than ever.

Next, as the joyful mood reached a climax, Dr. Simpson leaped up from his chair and stood on his head in the middle of the room, waving his feet in the air. Mrs. Simpson tried to get him out of this undignified posture, but before she could reach him he fell with a crash onto the floor, where he began to snore loudly. Mrs. Simpson, too, was soon overpowered with sleep.

On awaking, Simpson's first perception was mental. "This is far stronger and better than ether," he said to himself. His second was to note that he was prostrate on the floor. Hearing a noise, he turned round and saw Dr. Duncan beneath a chair—his jaw dropped, his eyes staring, his head bent under him; quite unconscious, and snoring in the most determined manner. Dr. Keith was waving feet and legs in an attempt to overturn the supper table. The naval officer, Miss Petrie and Mrs. Simpson were lying about on the floor in the strangest attitudes, and a chorus of snores filled the air.

They came to themselves one after another. When they were soberly seated round the table once more, they began to relate the dreams and visions they had had during the intoxication with chloroform. When at length Dr. Simpson's turn came, he blinked and said with profound gratification: "This, my dear friends, will give my poor women at the hospital the alleviation they need. A rather larger dose will produce profound narcotic slumber."

Indeed this scene, which might have been taken from a slapstick comedy, was to be the prelude to a new epoch. For the next scene belongs to the most tremendous moments in the history of suffering mankind. It discloses the first mother to be freed from the primal curse, the first mother to bring a child painlessly into the world.

Here is Dr. Simpson's own report:

"The lady to whom it was first exhibited during parturition had been previously delivered in this country by perforation of the head of the infant, after a labour of three days' duration. In this, her second confinement, pains supervened a fortnight before the full time. Three hours and a half after they commenced, and ere the first stage of the labour was completed, I placed her under the influence of the chloroform. The child was expelled in about twenty-five minutes after the inhalation was begun. The squalling of the child did not, as is usual, rouse her; and some minutes elapsed after the child was removed by the nurse to another room, before the patient awoke. She then turned round and observed to me that she had enjoyed a very comfortable sleep, and would now be more able for the work before her. In a little while she remarked that she was afraid her sleep had stopped the pains. Shortly afterwards her infant was brought in by the nurse from the adjoining room, and it was a matter of no small difficulty to convince the astonished mother that the labour was entirely over, and that the child presented to her was really her own living baby."

* * *

A Cents-ible Idea

A novel way of getting up funds for war relief has been adopted by some of the railroad men in Canada. Each time one of the boys says a bad word, he has to put a penny in the contribution box.

At the end of one trip they had $9.56—and that means a lot of cuss-words even for a Canadian train crew.

—Hospital Topics

Historic Hospital in Bristol Bombed

St. Peter's Hospital was originally built about 1500 as the residence of a famed alchemist, Thomas Norton, but it was embellished and much altered in 1612 by Robert Aldworthy. The front was a rich specimen of timber work with carved brackets and gables and wide projecting windows.

After being a merchant's residence it was converted into a sugar refinery. Later it was transformed into a Royal Mint, where many millions of silver coin were struck in the reign of William III. In recent years it became the offices of the Bristol Board of Guardians and the Registry Office for Weddings.

This splendid example of a mediaeval timbered building was destroyed by enemy action in November 1940.

For this illustration we are indebted to Mr. John Dodd, Director of the Bristol Hospitals Fund and Honorary Secretary of the Bristol and District Divisional Hospitals Council.

Why Not Use Unbleached Cotton?

Lower Price, Speedier Delivery and Greater Durability Offset Changed Appearance

To-day, when cotton goods are so difficult to obtain, how much are we prepared to pay for the privilege of keeping everything, theoretically at least, "as white as the driven snow"? The war should bring home to hospital administrators the advantages of having manufacturers use unbleached, instead of bleached, cotton cloths in the manufacture of operating and bed gowns, sheets, pillow cases and other textile items in use in the hospital.

At the present time approximately 66 per cent of the output of Canadian textile mills is being devoted to the Army, Navy and Air Force. Covers for air port runways, camouflage nets, tarpaulins for army trucks and other vehicles and hoods for airplane motors to speed warming up, are but a few of the many uses to which tremendous yardages of cotton are being put in war work.

Much of this material must be bleached before dyeing processes convert it into the required colours of the armed forces. This alone places the bleaching facilities of the mills under constant pressure, with the result that material for civilian use is often held up in the mills for considerable periods with consequent slowing up of deliveries.

As to cost, standard bleached cloths sell, wholesale, for from 2 to 5 cents per yard over the cost of unbleached. This effects a saving of from $2.00 to $3.60 a dozen on operating gowns alone. Add to this the longer life of unbleached fabrics, which may exceed by 25 per cent the life of bleached materials, and the economic advantages of the unbleached item are convincing.

It is an interesting fact that there are, to the trade, over 3,000 degrees of whiteness. The term "white" is, therefore, at best not a very definite designation of colour. After an unbleached cloth has been subjected to three or four launderings its appearance is not at all objectionable. It may well be that before long, hospital staffs and patients may feel quite at home with the unbleached cottons of bygone days.

Plucking £8,000 from Britain's Hedges

Many and ingenious are the methods which the British people have found to outwit the food shortage caused by the war. Last autumn, for instance, countrywomen, Boy Scouts, Girl Guides and schoolchildren searched Britain's hedgerows and commons for the rich annual crop of hips, the bright-red fruit of the wild rose. These are turned by manufacturers into a syrup, twenty times richer in Vitamin C than orange juice, now very scarce. This quantity will meet the requirements of 2,500,000 babies for a year.

The syrup manufacturers pay two shillings per stone for the hips, so that the gatherers, apart from maintaining the health of Britain's babies, will have earned something like £8,000 for their organizations all from fruit which normally goes to waste.

Hospital Masks: Their Bacterial Filtering Efficiency and Resistance to Air Flow

THE use of masking to prevent the carrying of droplet borne disease such as meningitis and pneumonia and operating room infections of clean wounds suggests the importance of a study of the relative efficiency of the different types of masks in common use.

Impermeable masks, however efficient they may be in preventing the direct projection of bacteria from the nose and face, deflect rather than entrap the droplets and thus do not decrease the atmospheric pollution.

The results of the different types of masks are shown in Table 1. Tests of effects of laundering indicated the gauze masks reached highest filtering efficiency and resistance to air flow after 20 washings. A relatively thick layer of absorbent cotton in gauze gave results comparable to a 6 layer washed gauze mask.

Arnold reported 100% bacterial efficiency for 6 layers of cellucotton. Our results indicate that 8 layers of cellucotton have a filtering efficiency of 97% and less resistance than 6 layers of gauze. But if cellucotton is to be used the difficulty of holding it in place and of sterilizing it must be overcome.

Those types having high air resistance are considered unacceptable because in use they would function as deflectors and not reduce air pollution.

1. In general the laundering of gauze enormously increases its filtering efficiency with only slight increase in its resistance to air flow. This efficiency reaches its maximum after 20 washings. A 6 layer mask showed a filtering efficiency of 97% after 20 washings.

2. Cellucotton showed an advantage in both filtering efficiency and low resistance to air flow but has certain disadvantages for use in masks.

3. Materials having the same resistance to air flow vary widely in their bacterial filtering efficiency.

Bacterial Filtering Efficiency and Resistance to Air Flow

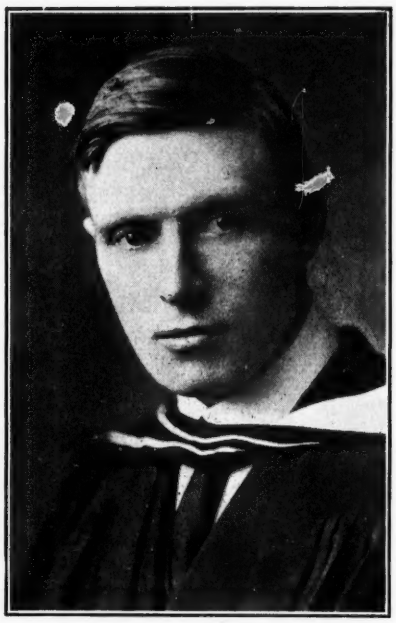
	Filtering Efficiency %	Resistance in mm. of water
Gauze (washed 50 times)		
2 layers	74.0	2.0
3 layers	79.0	3.0
4 layers	88.0	4.0
5 layers	93.0	5.0
6 layers	97.0	6.0
2 layers with ¼" air space between layers	70.0	2.0
2 layers containing thin layer of absorbent cotton	89.0	3.5
2 layers containing medium layers of absorbent cotton	92.0	4.0
2 layers containing thick layer of absorbent cotton	97.0	6.5
Other materials		
Cellucotton 8 layers	96.0	4.0
Flannel, wool, virgin, 42 x 42 strands, 1 layer washed	100.0	13.5
Cotton Flannel, 65 x 46 napped both sides, in thin gauze	98.0	11.0
Same after 50 washings	99.0	15.5
Broadcloth, single layer	41.0	15.0
Flannel, cotton, medium outing 46 x 42 strands napped both sides, 1 layer medium weight, washed 50 times	98.0	11.0
Air spun rayon, 2 layer, washed 50 times	92.0	8.5
Silk, flat crepe, single layer	83.0	8.5
Preferred types		
Cellucotton, 8 layers	97.0	4.0
Gauze, 42 x 42, 6 layers, washed 20 times	97.0	6.0
Gauze, 42 x 42, 2 layers, washed 20 times, containing a single layer of thick absorbent cotton	97.0	6.5

From *Public Health Reports, July,* 1941
By Hospital Abstract Service.

Price Trends

(On basis 1926=100)

	Yearly Average 1940	Nov. 1940	Oct. 1941	Nov. 1941	Dec. 1941
Building and Construction Materials	95.6	98.5	111.1	111.2	
Consumers' Goods (Wholesale)	83.4	84.9	96.7	96.8	
(On basis 1935-1939=100)					
Cost of Living	105.6	107.8	115.5	116.3	115.8

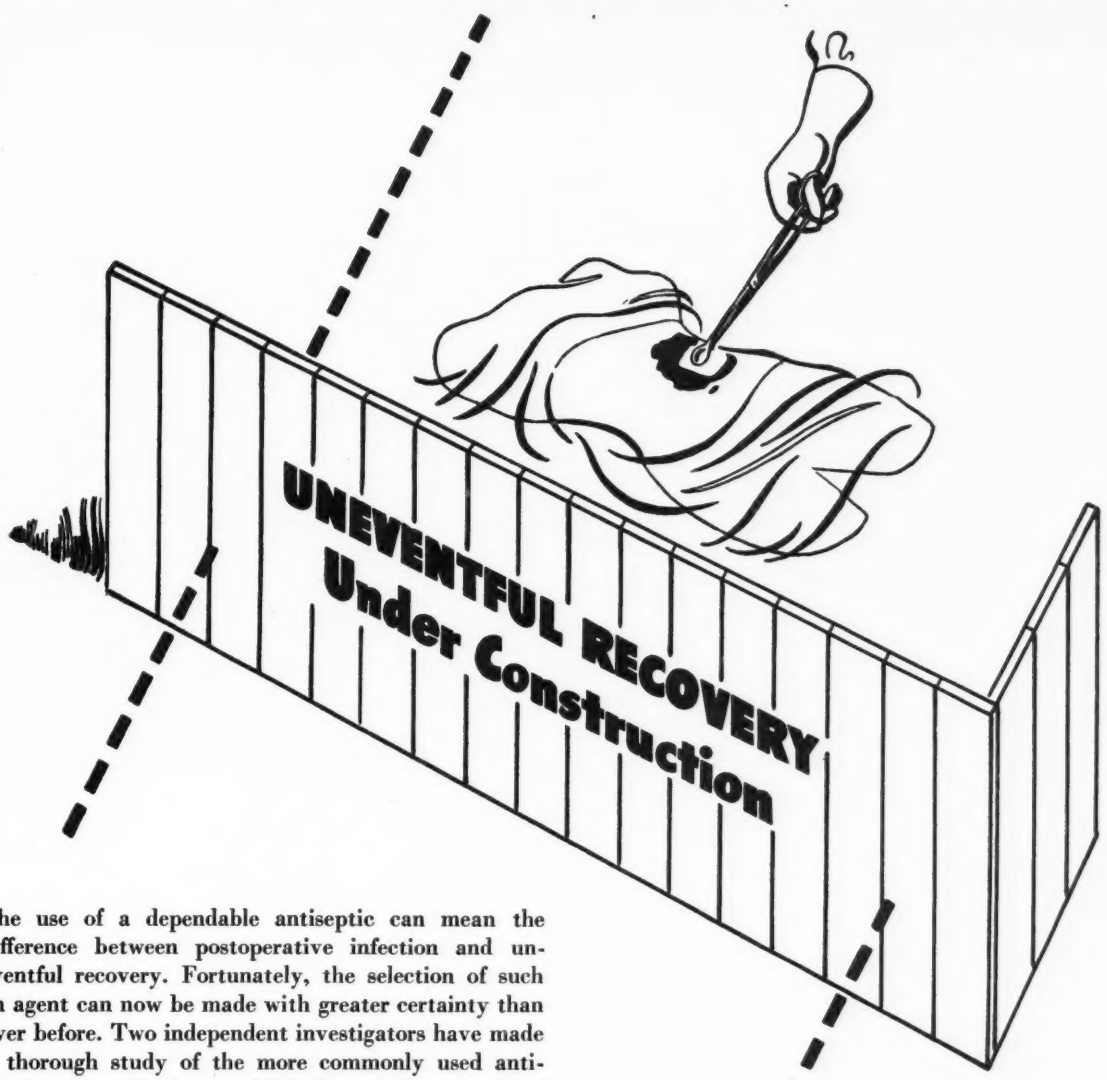


Dr. J. B. Collip Honoured

The Charles Mickle Fellowship, awarded by the University of Toronto to the doctor considered to have contributed most to the advance of medical science over the decade, has been given to one of its own distinguished graduates, Dr. James Bertram Collip. Dr. Collip graduated from Trinity College and was later Professor of Biochemistry at the University of Alberta. For some years he has been at McGill University, first as Gilman Cheney Professor of Biochemistry and more recently as director of the newly-formed Institute of Endocrinology. The Institute has been created to encourage and facilitate further investigation in the physiology and biochemistry of ductless glands. It has chosen for its Head a scientist who has evinced a long and successful interest in that particular field.

Dr. Collip has received many high honours from various universities, has been made a Fellow of the Royal Society of London and of the Royal College of Physicians in London, and shared in the Nobel Prize when insulin was discovered, in the isolation of which his biochemistry knowledge played a large part.

The editor looks back with interest to his days in the biochemistry laboratory, when that disheartening subject was made to glow and live for him by the kind efforts of an enthusiastic but unknown young demonstrator, one J. B. Collip.



The use of a dependable antiseptic can mean the difference between postoperative infection and uneventful recovery. Fortunately, the selection of such an agent can now be made with greater certainty than ever before. Two independent investigators have made a thorough study of the more commonly used antiseptic agents and have published a complete report of their findings.* *Tincture Metaphen was designated the most effective agent tested.* On the oral mucosa, Tincture Metaphen 1 : 200 was found to reduce bacterial count 95% to 100% within five minutes; to have, in substantial excess over any other antiseptic agent tested, a duration of action of two hours; and to produce only slight irritation in some cases, none in others. Metaphen does not appreciably precipitate blood serum; does not affect surgical instruments or rubber goods; and is quite stable when exposed to air in ordinary use. If you are not already using Tincture Metaphen 1 : 200, give it a trial. It is available in pharmacies everywhere in 1-ounce, 4-ounce, 16-ounce and 1-gallon bottles. ABBOTT LABORATORIES, LIMITED, 20 Bates Road, Montreal.

Tincture

Metaphen

(Tincture of 4-nitro-anhydro-hydroxy-mercury-orthocresol Abbott)

*Meyer, E., and Arnold, L. (1938), Amer. J. Digest. Dis., 5: 418.

Canada's *health army is mobilized!*

INTO THE SPOTLIGHT today comes the work of nearly 200,000 people engaged directly or indirectly in caring for the sick and preventing disease. For Canada now realizes that as vital as arms and munitions to the nation's defense is the *health of its people.*

Behind those of Canada's Health Army actually serving with the armed forces, the effort of every nurse and physician in the interest of public health is a direct contribution to the strength of the democracies.

To you of the medical profession is entrusted the great responsibility of maintaining the nation's health in this emergency . . . and to the medical supply and equipment manufacturers, the task of maintaining the quality and quantity of essential pharmaceuticals, apparatus and supplies.

Mindful of its part in this responsibility, Patterson has taken steps to insure the availability of both fluoroscopic and intensifying screens. An ample supply of raw materials is in hand. Research and testing facilities have been expanded. More than adequate production is being maintained. The roentgenologist may rest assured that Patterson screens will continue to give that degree of extra performance that has made them the world's standard of quality.

THE PATTERSON SCREEN CO.
TOWANDA, PA., U. S. A.

PATTERSON'S
facilities devoted 100%
to Public Health and Defense
of the Democracies

Patterson X-Ray Screens

With The Auxiliaries

Shopping for Hospitalized Patients

One of Activities of Moose Jaw Women's Auxiliary

At the Annual Meeting of the Moose Jaw General Hospital Women's Auxiliary, the treasurer's report showed a total of $1,168.99 raised during the past year. Most of this money has been spent directly on the hospital and its patients.

The nurses especially have benefited from the auxiliary's efforts. Metal dressers were bought for all the bedrooms in the residence, and it is proposed to add metal chairs and study tables for each room next year. A new electric iron, a radio-table and a substantial share in the cost of a new radio were some other of the auxiliary's contributions to the well-being of the student nurses.

Nor is the rest of the hospital neglected. Two complete wards have been furnished by these willing workers, and what is more, they are kept in repair and a new coat of paint as needed. The sewing circle, meeting once a week, has in the past year completed 4483 articles for hospital use. Both nurses and patients are remembered at Christmas. and the Visiting Committee spends one day a week in the hospital, distributing magazines and papers to the patients. One very thoughtful and practical help which is given the patients is worthy of special mention. The committee members do odd bits of shopping for the patients, especially for those from out of town, a service which is much appreciated.

It is interesting to note that when the annual membership drive was held last March and April, the membership was more than doubled.

* * *

Saint John General Hospital

Among the many gratifying reports received by the Women's Hospital Aid for providing Christmas treats to patients in the General and Tuberculosis hospitals was a letter from seven women patients on the sixth floor of the General Hospital expressing appreciation for the gifts the Aid had supplied for them and their babies.

A large quantity of medicine bottles for the General Hospital and a supply of magazines for both hospitals were received at the meeting, but members were urged to secure still more of these articles, the magazines being especially welcome.

It was voted to give $10 to the nutrition section of the Canadian Red Cross Corps to be used for purchasing refreshments for the Red Cross blood donors' clinic. The sum of $10 each was voted for books for the nurses' libraries in the General and Tuberculosis hospitals.

* * *

St. Joseph's Hospital Auxiliary, Saint John

At the quarterly meeting of the auxiliary Mrs. Carl V. Belyea, President, gave a summary of the work. A generous amount has been given towards an anaesthesia machine, *The New Freeman* is being distributed to the patients in the hospital, and copies of *You and Your Baby* are given to new mothers on leaving the institution.

The auxiliary has collected 399 jars of jelly for the Sisters to use in the hospital.

The Rev. Gerald Koster, C.S.S.R., addressed the meeting.

* * *

Evangeline Hospital Auxiliary, Saint John

The Evangeline Hospital is a splendidly equipped maternity hospital, staffed entirely by Salvation Army nurses. The past year has been a very successful one in the work of the auxiliary. One semi-private ward has been completely furnished and a four-bed semi-private room has also been renovated and furnished.

This work was financed by money made at rummage sales, the annual supper and sale, and talent money. Mrs. J. G. Bruce is the President, taking over office from Mrs. Murray Holly.

Women's Auxiliary, Jewish General Hospital, Montreal

One of the most active and capably-run hospital auxiliaries in Canada has submitted its annual report for 1941. A total of $13,083 has been raised during the year for the hospital. Of this amount $4,627.99 was laid out in the supplying of the complete hospital linen requisition for the year.

New X-ray equipment was provided for the hospital, and $3,000 was set aside for the purchase of radium. Vitamins for the obstetrical clinics and a weekly contribution of $5 for insulin for indigent diabetics were also provided.

An electric food conveyer for the public wards and a resuscitator for the new-born were also donated by the auxiliary. Nursery supplies, dispensary bottles, dressings, layettes and the total upkeep of the blood donors' clinic were also provided by the energetic women of the auxiliary.

A contribution was made for the replacement of small instruments and a medical library fund established.

A marked increase was shown in the membership for the year, and 150 new members have already been added for 1942.

No More Rubber Heels!

Hospitals would be well advised to consider the purchase of sufficient rubber heels to meet their needs. It has been announced that, as part of the programme to conserve rubber, heels made of rubber are to go off the market. If all hospital nurses, maids and others constantly using the corridors must go around with leather heels, possibly steel-shod, the comfort of the patients will be greatly reduced. As no other vocational group are as justified in wearing rubber heels as those who must frequent hospital wards, it would seem in order that hospitals might consider purchasing for use by their personnel a sufficient quantity to meet their needs for the next year or two. This point might well be discussed with the director of the school for nurses.

Correspondence

"Recovered" or "Improved"?

To the Editor:

In summarizing our monthly "discharge of patients", the question has arisen amongst the medical staff as to where the line should be drawn in designating patients as RECOVERED and IMPROVED.

For instance, the obstetrical patient on discharge after 12 days in hospital obviously is improved, but she is not completely recovered until she has a period of convalescence; there are many other examples much the same.

Yours sincerely,
—— R.N., Superintendent.

VERY little has been written concerning the differentiation between "recovered" and "improved". Perhaps the most helpful paragraph occurs in Dr. Malcolm T. MacEachern's work "Medical Records in the Hospital", page 246, in which it is stated:

"There has been some confusion as to the terms 'recovered' and 'improved', a confusion which need not arise if it is kept in mind that the result being stated is the result of treatment carried on as it is evident at the time of discharge. The question should be asked: 'Has the patient recovered from the condition for which he sought treatment?'"

It is our general impression that medical staff members and record librarians would place a normal obstetrical patient in the "recovered" group. It is true that she is not entirely well but the designation "improved" might be more aptly applied to those obstetrical patients who are discharged, say with a perineal tear, still requiring treatment or to a prenatal case in for pernicious vomiting or eclampsia. A case of appendectomy or herniotomy might be still far from well on discharge but they would be sent out as "recovered" and only marked "improved" if they had a residual stitch, abscess, wound breakdown or other complication requiring further treatment.

One doubts if we should be too literal in interpreting these terms; otherwise we could hardly say "recovered" for many of our patients. Most hospitals are inclined to reserve the term "improved" for such conditions as carcinoma, peptic ulcer, arthritis and such other conditions in which a complete recovery, after a short period of convalescence, cannot be anticipated.

In the case of removal of a knee-joint to provide fixation, as in a case of infantile paralysis, one would be inclined to discharge the patient, after operation, as "cured". In other words, while the paralysis would still exist, the condition for which the patient was operated on, that is, mobility of the knee joint, had been cured, even though the convalescence might take three or four months. *—Editor.*

Who is Responsible for Pre-Operation Urinalysis?

Dear Sir:

Is there any regulation stating that "routine laboratory examination of urine for all pre-operative patients" is the responsibility of the Hospital, or is this an individual procedure ordered by the Doctor?

Yours very truly,
—— ——, R.N.,
Superintendent

Reply

In your province, (Ontario), the provincial regulations under the Public Hospitals Act, Section 41, state:

"A complete history, physical examination and a written pre-operative diagnosis shall be furnished by the operating surgeon or any medical practitioner authorized by him before a patient is submitted to any anaesthetic or surgical operation, provided that where the surgeon is of the opinion that the delay occasioned in obtaining such history and examination would be detrimental to the patient, he shall so state in writing, and in such event the pre-operative diagnosis shall be furnished in writing and signed by the operating surgeon."

This regulation does not specifically mention a urinalysis, but it might reasonably be interpreted by the courts that one can not do a proper physical examination without doing a routine urinalysis.

To the best of our knowledge most hospitals now routinely require urinalysis before operation, except in case of dire emergency. If a patient suffering from unrecognised diabetes or uremia died following an operation, those responsible for the omission of this safeguarding test would be in a very unsound medico-legal position.

As to whether it would be the responsibility of the hospital or the doctor might be difficult to generalize; we do not recall a decision on this specific point. In a private case it is possible that the doctor would be held responsible, but in the case of an indigent it is likely that the hospital would definitely share in the responsibility, for, while the hospital which has exercised due care and judgement in the selection of its medical staff is not responsible for the individual actions of its doctors, it is nevertheless required to exercise proper safe-guards for the indigent patient entrusted to it by the state. As a matter of fact, in most institutions the regulation is a hospital one, applicable to all patients. Such regulations are usually recommended or approved by the medical staff and endorsed by the hospital board.

—Editor.

New York State to Suspend Nurses' Practice Act

The Nurses' Practice Act in New York state, scheduled to go into operation on January 1st, 1942, is reported to have been suspended for the duration of the war. Designed as a measure to control the practice of nursing and to require all nurses to be registered and licensed, the act was a most commendable one; but it is now realized that during the present emergency such control would bring about a shortage of nurses which must be overcome, even though it means a continuation of somewhat lower standards.

Should a Manufacturer Sell *ALL* Hospitals at the *SAME* Prices?

WE operate the only Cellulose mill in Canada. We know the quality of our Cellulose is acceptable to Canadian hospitals. But we still have a lot to learn about *selling* our Cellulose to Canadian hospitals.

To illustrate: We now quote the *same* prices to *all* Canadian hospitals, large or small. Many firms, we understand, vary their prices to a considerable extent in favour of the buyers of large quantities of supplies.

It has been our policy to publish our prices openly, and as widely as possible, naming the *same* price to *all* hospitals.

Are we right in so doing? Are we fair to Canadian hospitals and to ourselves in so doing?

Every hospital administrator, every doctor attached to a Canadian hospital, every hospital nurse and every hospital worker is invited to send us their ideas.

$100.00

IS OFFERED TO OBTAIN THE BEST ANSWERS TO THIS PERTINENT QUESTION

Are we right?

What do YOU think?

To the writer of the letter containing the best answer to the question—"Should a Manufacturer sell *all* hospitals at the *same* prices?"—we will send our cheque for $50.00. To the next best letter writer, $25.00; to the third $15.00; and to the fourth, $10.00.

The Editor of "Canadian Hospital", the Managing Editor of "Canadian Hotel Review" and the President of our Company have kindly consented to act as judges.

All letters will be treated confidentially. The decision of the judges will be final.

As the judges will start their judging early in May, all letters to be considered must be mailed by April 30th, 1942.

National Cellulose of Canada, Limited

1-21 Clouston Ave., Toronto

Some Comments on Hospital Charges

From the Report of the Committee on Finance of the Canadian Hospital Council

Hospitals are often the subject of *discrimination,* largely because they have failed to assert themselves and to insist on consideration and treatment commensurate with that extended to other lines of business. It is unfortunate that a number of our hospital boards and administrators are living too far back in the past. They do not seem to appreciate that the ideas or ideals which were prevalent at the time when hospitals were first started in the form of nursing homes for the poor are past, and that to-day the operation of hospitals is "big business". From the standpoint of capital investment, payrolls, etc., we represent one of the largest groups of businesses in the Dominion and definitely one of the most essential. We can surely retain that humanitarian outlook of our hospitals in providing care and treatment for the sick and injured and yet at the same time reserve the right to require that under our present social set up, the actual *cost* of such services shall be paid by our governments—federal, provincial or municipal. When we refer to cost we have also in mind the fact that some hospitals have rates lower than their costs but these hospitals would be prepared to accept their regular rates.

We may acknowledge among ourselves that hospitals are in financial difficulties due to some extent to their own neglect. Hospital associations are urged to devote more time to analyzing and remedying ills and less time to reviewing past and current activities and bemoaning their financial fate. Associations should discard the tendency to discount the social value of hospitals and the inclination towards an inferiority complex, and recapture the support of disinterested hospitals losing ground financially because of the contagion of defeatism. The importance of hospitals to individuals, corporations and the government should be emphasized.

Another contributing factor is a lack of *unity of purpose.* Every individual hospital should co-operate with other hospitals in its own community, also with its provincial or local organization. Every local organization, provincial or other, should support the Canadian Hospital Council. It is intended that in this way we shall develop a definite co-operation and understanding between hospitals in the matter of rates, policies, etc. This is very desirable and commendable, especially if it achieves the desired results. A number of our problems are definitely national in scope and we need to develop that same unity across the Dominion. We do not suggest any form of combine. We appreciate that due to labour conditions, cost of supplies, accessibility, etc., there will be a variance in per diem costs across Canada, and in the same way there will be a variance of rates charged. We even have this condition existing within a community, based on type or control of hospitals.

Dean Conley New Secretary Of A.C.H.A.

Mr. Dean Conley has been appointed executive secretary of the American College of Hospital Administrators to succeed Mr. Gerry Hartman, who has become administrator of Newton Hospital in Newton Lower Falls, Mass.

For some years Mr. Conley has been business manager of the Students' Health Service at the University of Minnesota and has been associated with the University of Minnesota Hospital. He has been in charge of the construction of the new Students' Health Hospital at the University and has participated in a number of institutes for hospital administrators.

Put Your Dollars In Battle Dress

Leprosy Care in Korea

Leprosy is very common and though about four thousand are segregated in the three missionary and one government leprosariums, thousands still wander at will through the country. We are apt to think of leprosy as a disease of the tropics but Korea is in a temperate zone with severe cold in the north and at least some snow and ice in the south in winter. It is true that most of the lepers of Korea are found in the south but it has been ascertained that the reason for this is that most of the northern lepers wander south to escape the rigors of the northern winters.

Cure of leprosy is not uncommon especially in early cases, but early cases coming to attention are rare because when a victim first becomes suspicious that he has the disease he seeks to keep it secret, in order to avoid social ostracism. In the missionary leprosariums every effort is made to provide a normal life for the inmates. They are given employment in the trades or as farmers and, after sterilization of the men, marriage is encouraged and when possible leper children are provided to form family units. They form their own town councils, conduct their own churches and schools and some are trained to do necessary dressings, give the injections of cholmoogra oil and even to perform amputations. These colonies are very popular and it is a sad sight to see the many lepers outside the gates begging to get in, but for whom there is no room because of insufficient funds. It takes between fifty and sixty Canadian dollars to keep one leper for a year.

From a paper by Douglas Avison, M.D., to the Academy of Medicine, Toronto.

For Scrubbing Waxing and Polishing Floors

THE FINNELL *IS A WHIZ!*

And here are some other **GUARANTEED D-B PRODUCTS!**

Brushes	Mop Wringers
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Disinfectants	Sponges
Floor Dressing	Sprayers
Insecticides	Sterilizing Compound
Linseed Soft Soap	Sweeping Compound
Liq. Scrub Soap	Toilet Soap (bars)
Liq. Toilet Soap	Toilet Tissues
Lemon Polish	Whisks
Metal Polishes	Waste Receptacles
Mops (wet)	Wax-Paste and
Mops (dusting)	Liq. Self-Polishing
Mop sticks	

Yes, Sir! THE FINNELL is Quicker, Safer Quieter!

It does the work in less time, with less labour, at less cost. It cleans, scrubs and polishes under desks, tables, benches. Its super off-set design enables it to go anywhere and everywhere and it does a real job everytime.

The best proof of Finnell superiority is that more Finnells are sold than any other type of machine. Many units are still in operation after 15 years of service. There's a right size Finnell for every floor servicing requirement—each one equipped with a General Electric Motor.

WRITE FOR ALL THE DETAILS.

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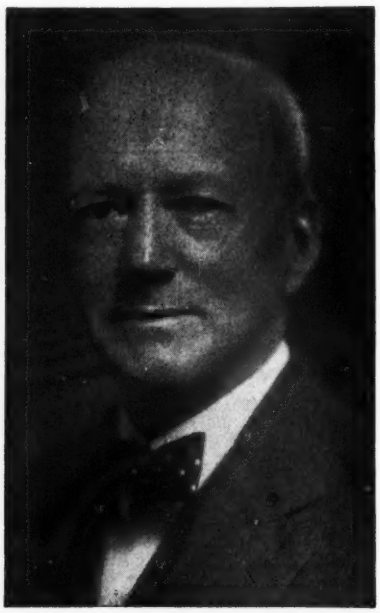
SAINT JOHN — WINNIPEG — VANCOUVER

A Tribute to the Hospital Laboratory

THE hospital laboratory, with its batteries of scientific apparatus and instruments of precision, has probably done more than any other one factor, in or out of the hospital, to relegate empiricism and the trial-and-error methods of yesterday, to the rearmost shadows of that great humanitarian stage, known as the practice of medicine, whereon there is daily played, all over the world, the never-ending drama of life and death. The hospital laboratory is a domain wherein the microscope, both figuratively and actually, holds the centre of the stage. To those who will look carefully it reveals the existence, around and about them, of another fantastic and seemingly infinite world, crowded and teeming with life, in the midst of which mankind lived for hundreds of thousands of years, totally unaware and unsuspecting of its existence; a universe within a universe, containing myriads upon myriads of living creatures which eat and drink and reproduce their kind and fight and die, but which are so small that a colony made up of many thousands of them might veritably rest upon the point of a needle and thereon remain invisible to the unaided human eye; creatures differing as widely in their types of form and structure and in their habits and customs as the various members of that larger, visible animal and vegetable kingdom of which we ourselves are an integral part; armies of builders and armies of wreckers, each as energetic in its respective realm as Maeterlinck has so vividly pictured the busy bee; groups with potentialities for good and groups with potentialities for evil, so immeasurable in comparison to those same traits as found in man and his brother animals of the visible world, as to cause these latter to fade into pale insignificance.

The hospital laboratory has become the chemical warfare and intelligence divisions combined of that world-wide army which is devoting its energies to the fighting of disease, pestilence and death. It is at one and the same time a sentinel ever on guard to warn of the approach of stealthy or unsuspected foes; a prompt and efficient scout and messenger to give word of the battle's trend; a powerful telescope to render visible the approach of an attacking enemy while the latter's armies yet remain indistinguishable to the unaided human eye; and a factory for the manufacture of munitions of war, with which to put the armies of dread disease to rout. The laboratory as the secret intelligence and research bureau serves not only in the formulation of plans and campaigns against the enemy, but likewise for the discovery and development of those mysterious and marvellous deadly chemical formulae, through the discovery and later dissemination of which the foes of life and health are slowly, one after another, overcome or held at bay pending reinforcements from the same trustworthy source. It is a citadel of offence and defence, and it is quite commonly the final determining factor as to whether the beseiged shall repulse the enemy or be overcome in the battle and perish.

From Hospitals and The Advancement of Science, by Charles E. Remy, M.D., in The Scientific Monthly.



B. Evan Parry

Hospital workers everywhere will hear with regret of the sudden death in Toronto on January 25th of B. Evan Parry, F.R.A.I.C. In his 66th year, Mr. Parry has long been known to the hospital field as a specialist in hospital architecture.

Born in England, he came to Canada before the Great War, but returned to serve in the army. Coming back to Canada in 1919, he was for 13 years architect-in-chief of hospital and other construction in the federal government. He came to Toronto in 1932, and was in private practice for two years in the firm of Smith and Parry. More recently he has been editor of a feature page on construction and home furnishing in *Chatelaine Magazine*. Many fine hospitals throughout Canada have been designed by Mr. Parry. He was always an enthusiastic supporter of the Canadian Hospital Council, and contributed extensively to its studies on construction and to the pages of this Journal. At the time of his death he was head of the Publicity Committee of the Ontario Association of Architects and chairman of the Research Committee of the Royal Architectural Institute of Canada. He was also chairman of the Toronto Men's Hostel Board.

To Mrs. Parry there is extended the deep sympathy of their many hospital friends.

Surgical Instruments Still Needed

Allied Equipment Low

There is still urgent need for surgical instruments of all kinds in Russia and elsewhere. A tremendous amount of surgical equipment, mainly small instruments, has already been donated, and much of it sent, to the Russian army, but more is desired. The staggering number of casualties, the rapid movement of troops and the unprecedented loss and destruction of equipment has made it utterly impossible for the medical corps attached to the Russian army to equip its medical units with adequate supplies. Undoubtedly there are many practitioners who could supply some of their instruments, and in many hospitals there must be instruments which are seldom used and which could be donated for use at the front. Packages or boxes of instruments could be forwarded to the office of the provincial medical association or could be sent directly to the Canadian Red Cross Society.

Q. Canning's a pretty old method of preserving foods, isn't it?

A. No. On the contrary it's comparatively new. Methods of food preservation, such as smoking and drying fish and meats, are thousands of years old. However, canning was first successfully employed in the early years of the 19th century. The improvements of modern canning procedures are the direct outgrowth of many achievements of modern science. (1)

American Can Company, Hamilton, Ontario;
American Can Company Ltd., Vancouver, B.C.

(1) 1811. The Art of Preserving All Kinds of Animal and Vegetable Substances for Several Years, M. Appert, Black, Perry and Kingsbury, London.
1938. Food Research 3, 13.
1938. Ibid. 3, 91
1939. Canned Food Reference Handbook, American Can Company, Hamilton, Ont.
1941. Ind. Eng. Chem. 33, 292

Power Shortage Provides Unexpected Blackout Test

A power shortage in the main panel board suddenly blacked out the 500-bed Toronto Western Hospital for 4 hours on January 23rd. It was a totally unexpected and "all out" test of the hospital's preparedness for blackout. Now that it is all over, and with no deaths from mishap, the hospital authorities are pleased to have been forced to go through this experience, as it did reveal the remarkable extent to which the hospital could rise to the emergency.

At 9.15 p.m. the lights went out and the elevators stopped, as did everything else electrically operated. There was no panic. The nurses immediately put their emergency flashlights into use, candles and blackout lanterns were lit. The general superintendent, Mr. A. J. Swanson, was summoned and took charge of the situation. The day staff was brought back on duty. All the elevators stopped, two of them between floors. Fortunately only the operators were on the elevators. A confinement case in the case room on one of the upper floors was carried down one floor to her room. Another obstetrical case was admitted during the blackout period, but she was looked after on a lower floor, without going to the obstetrical suite. Several emergency cases came in, but these were handled in the usual manner and put to bed on the ground floor.

Had this been in actual warfare a number of casualties could have been handled on the lower floors without the use of the elevators, for there was considerable space available for emergency admissions in the outpatient department, the X-ray department and the physiotherapy department, all located on the lower floors. Had these patients required surgery, this could have been handled easily, for the operating suite is only on the second floor and battery-operated emergency lights are available. The instrument sterilizers are heated by steam and are thus independent of a power shortage. The water supply on the top floors might have been a problem over a longer period, as this hospital, the highest in the British Empire, requires to have the pressure for the upper floors boosted within the hospital. The shortage caused no serious inconvenience, however, for this short period of time.

Fortunately the telephones were not affected, so that communication with all parts of the building by telephone was maintained. One wing of the hospital has auxiliary gas lighting, which was utilized. The hospital also has an auxiliary Diesel-powered engine which would replace a power shortage from outside; in this case, however, the trouble was in the hospital's own panel board.

Book Reviews

DOCTORS ANONYMOUS. By William McKee German, M.D., Pathologist to the Good Samaritan Hospital, Cincinnati, formerly of Michigan Medical School and formerly Pathologist to the Blodgett Memorial Hospital, Grand Rapids, Mich. Introduction by Paul de Kruif. 300 pp. Price $3.50. Duell, Sloan and Pearce, Inc., New York. Messrs. Collins, Toronto. 1941.

This very readable book tells the story of the pathologist—the "doctor's doctor" whom patients seldom see but who makes or confirms their diagnoses. Written primarily for the layman, it vividly portrays the thrills, the fears, the heartbreaks of medicine as seen in the laboratory. Doctor German has had a long and interesting career and has illustrated his story with many dramatic case incidents. Although it will raise immeasurably the respect of the reader for the accuracy of modern diagnostic methods, it will not greatly increase his confidence in medicine as it is practised, for many of the illustrations do emphasize the lack of scientific knowledge or the over-confidence of the clinician. Perhaps that is as it should be, for the sooner non-scientific or careless medicine is exposed the better. To the layman of enquiring mind, or of apprehensive temperament, the sane logic of his chapters on cancer, on pregnancy and on autopsies will prove very helpful. It will prove helpful and informative reading to the hospital personnel, to the volunteer workers and to those of the general public who are interested in learning what goes on behind the scenes in the better hospitals. Perhaps hospitals with little or no pathologic oversight will not look so efficient to their supporters.

* * *

BRITISH MEDICINE. By R. McNair Wilson. One of a series entitled "Britain in Pictures." With 8 plates in colour and 20 illustrations in black and white. 48 pp. Price $1.25. William Collins of London; Messrs. Collins, Toronto. 1941.

This famous series of concise and authoritative works now contains a volume on British Medicine which achieves the non-too-easy task of condensing the great story of British Medicine into forty-eight pages. British Medicine has a glorious record. Harvey, Jenner, Lister, Manson, Mackenzie, to mention but a few, were but shining lights of a long series of illustrations victors over disease. Well written and well illustrated, this little work is both informative and interesting.

Fame and Wealth and a Free Appendectomy Await Poster-Competition Winners

The American Hospital Association has announced the conditions of its 1942 National Hospital Day Poster Competition. The purpose of the posters is "to create good will for the community hospitals of America and to publicize National Hospital Day and the health services rendered by non-profit voluntary hospitals".

The posters are to be in colour, black and white, or colour photography, and in any size proportionate to 14" x 22". The points to be stressed are the scientific, personal and social values of the community hospitals of to-day, which represent a concentration of trained personnel and specialized equipment for the prevention and cure of illness. The patriotic motive is to be emphasized through civilian rather than military defence, that is the hospital's contribution to national production and efficiency through preventive care and treatment of the civilian population.

Entries should be sent prepaid to the National Hospital Day Committee, American Hospital Association, 18 East Division Street, Chicago, Ill., not later than March 20, 1942. Do not sign on face of art work. On the back of each entry, print your name and address in space 3 by 5 inches. Also enclose a 3" x 5" card with your name and address typewritten. As many entries may be submitted as you wish.

The first prize will be $200, and three Honourable Mention prizes of $50 each will also be given. A novel feature of the contest is the fact that the four prize winners will have their hospital bills paid for the year May 1, 1942 to April 30, 1943, according to the terms of the service contract of the Blue Cross Plan in his residence area.

Interns Receive Questionnaire Respecting Enlistment

Interns serving in Canadian hospitals are now filling in a questionnaire with respect to their plans on the conclusion of their internship. This information is being collected by the Canadian Medical Association on behalf of the Defence Forces. In addition to personal data, including qualifications, the interns are asked as to their intention to enlist as medical officers in His Majesty's services, the likely date, and the intern's preference for service, as between the Navy, Army and Air. If not physically fit or not available for military service, the intern has an opportunity to state the reasons, although this is entirely optional.

The services have agreed not to call up interns during their junior internship, but are anxious to know the number of men who will be available in the near future and to have some idea of their preference as to service. It is understood that this questionnaire does not apply to American citizens.

Intern and Student Groups In U. S. A. Join Forces

The Intern Council of America and the Association of Medical Students have agreed to merge their two associations. The joint body will be known in future as the "Association of Interns and Medical Students". This effects an arrangement similar to that in Canada, where the two groups have been united since their organization several years ago in the Canadian Association of Medical Students and Interns, commonly referred to as the "Camsi".

Ask Hospital District Be Formed

The mayor of Taber, Alberta, has written to the provincial Bureau of Public Welfare to ask that an organizer be sent from the department to form a new hospital district there. Of the $50,000 needed for the undertaking, $30,000 has already been pledged.

New Dietitian at Toronto General Hospital

Miss Margaret Ketchen has succeeded Miss Winifred Moyle as chief dietitian at the Toronto General Hospital.

O. D. Johnston

O. D. Johnston, Manager of the Industrial Division of Gooderham & Worts, Limited, Toronto, has been elected Vice-President of this well-known distilling firm. The Company produces a wide range of industrial and pharmaceutical alcohols, as well as Hot-Shot Anti-freeze, and its output is now largely devoted to War Material requirements.

New Addition Proposed for V.G.H. at Halifax

Andrew Randall Cobb, architect, has been engaged by the Nova Scotia Government to prepare plans for the proposed new 300-bed addition to the Victoria General Hospital, Halifax, Nova Scotia. The office of William Henry Walsh, M.D., has been retained as hospital consultant.

Changes in Manitoba Hospital Service Benefits

A. L. Crossin, Executive Director of the Manitoba Hospital Service Association, reports changes in the benefits to subscribers, and an increase in the per diem to member hospitals. The Association now has a reserve in excess of three months premiums, and the changes are estimated to cost, on the basis of present membership, not more than $12,000 during 1942.

Is Your Subscription Paid?

Twenty Million Volt X-ray Machine Developed

The University of Illinois has produced a new X-ray machine capable of developing an energy of twenty million volts. This new apparatus, the rheotron, was designed by Dr. Daniel W. Kerst in association with General Electric engineers. The effect of this unprecedented electron stream upon human and other tissues is now being considered.

This group of research workers is now engaged in developing a still greater apparatus, which it is expected will create an energy of one hundred million volts.

A Memorial Hospital to Honour Memory of Paderewski

American admirers of Paderewski the Musician, have paid tribute in a way which would have pleased very much Paderewski the Statesman. The hospital built and named for him is now in operation in Scotland. This Edinburgh institution, in serving Polish civilians, Polish troops, serves the memory of one of Poland's staunchest patriots.

—Hospital Topics.

Storage and Handling of Gases

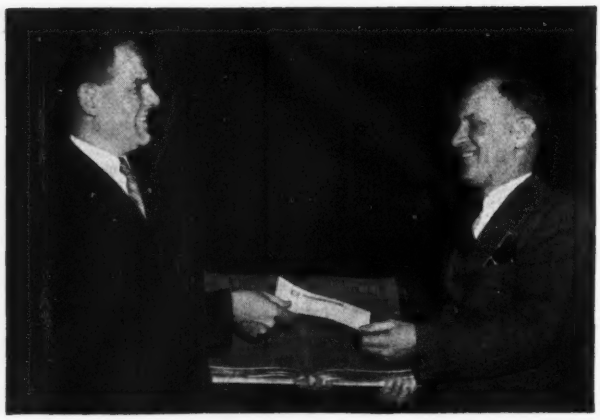
(*Concluded from page* 23)

thereof in each flammable gas and oxygen line, so located as to be accessible at all times for use in an emergency. These valves should be so arranged that shutting off the supply of gas to any one operating room will not affect the others. Valves should be of approved type and mounted on a pedestal or otherwise properly safeguarded against mechanical injury.

As defined in Section III, places where compressed flammable gases or flammable liquids are stored are considered as hazardous locations. The recommendations covering electrical wiring in hazardous locations and recommendations for the reduction of the electrostatic hazard should, therefore, be rigorously observed.

St. Luc's, Montreal, Approved

L'Hopital Saint-Luc, Montreal, has been approved as a school for the training of laboratory technologists in Bacteriology and Serology.



Award Winner for Year's Best Selling Performance

Hightlight of the Bauer & Black Sales Convention held at the Royal York Hotel in December was the presentation by (left) Mr. George Stineback, General Sales Manager, to Mr. T. Roy Rumley. Besides getting a substantial cheque, the winner also received an attractive gift for his home as well as having his name inscribed in the silver Book of Achievement which is a lasting record of each year's star Bauer & Black salesman.

$100.00 Is Offered In Interesting Contest

An announcement of National Cellulose of Canada, Limited, Toronto, in this issue of the Journal, invites administrators and other hospital workers to submit answers to the question, "Should a Manufacturer Sell All Hospitals at the Same Prices?"

To the writer of the best letter in this contest an award of $50.00 will be made; to the second best, $25.00; to the third $15.00 and to the fourth $10.00.

This is an opportunity for hospital buyers to express their views on a very interesting phase of hospital purchasing—with prospects of receiving a very substantial cash return.

All letters to be considered must be mailed by April 30th.

Deep Therapy Unit Installed At Owen Sound

A 200 KV deep therapy X-ray machine has been installed in the 102-bed hospital at Owen Sound, Ontario. This new machine has been donated as a memorial and costs in the neighbourhood of $7,400. The hospital at Owen Sound is one of the first of the medium-sized hospitals to instal such fine equipment, and in its location will be able to serve a large area in western Ontario. The director of the department is Dr. Gordon S. French.

Orange Juice on Lease-Lend Order

An increased flow of orange juice to British children and a saving of precious space in cargo ships are two of the benefits expected from the vast new plant of Citrus Concentrates, Inc., soon to be started at Dunedin, Florida.

So important is the citrus concentrate industry considered by the American government, that the Department of Agriculture has put up $1,500,000 for the construction of the new factory, and the necessary priorities have already been assured. By means of the new process, the concentrated orange juice will take up only one-twentieth of the storage space required by the whole fruit.

The first carload of concentrated orange juice in a $1,000,000 lend-lease order left for England in January.

H. P. Cowan, 42 Church St., Toronto, is the Canadian distributor of this product.

Silver-Lined Blackout Bulb Designed

Designed for blackout lighting in air raids, the new Wabash Blackout bulb just announced by the Wabash Appliance Corporation, Brooklyn, N.Y., provides downlighting in a soft beam of blue light that is safe for indoor visibility during blackouts. The bulb is lined inside with a pure silver reflector lining that hides all filament glare and projects the light downward. Light leaks are prevented by a black silicate coating that covers the bulb up to the extreme lighting end which is a deep blue. The new bulb consumes 25 watts.

Distributed exclusively in Canada by Ideal Electric, Inc., 705 Craig Street West, Montreal, and 21 King Street East, Toronto.

You Can Defend Them

(*Concluded from page* 26)

The myth of endangering women and children by assault and rape is empty of factual support in actual experience. The enforcement of laws directed against commercialized prostitution results not in an increase in assault but in a decrease.

The essence of suppression of commercialized prostitution by affective law enforcement lies in its power to render this prolific source of disease *less accessible*. Accessibility is the key point. It is obvious that prostitution can never be wiped out, but it can be made more difficult and be resolved to a man-woman relationship which is not exploited commercially by third parties.

The problem of prostitution is fundamentally a social and economic problem, the solution of which lies principally in the correction of numerous defects in our social fabric. Suppression of commercialized prostitution, as provided for by the Criminal Code of Canada, as demanded on behalf of a more efficient war effort and as approved by health authorities, seeks not to wipe out prostitution but to make it inaccessible and reduce it to a man-woman relationship free from the mercenary participation in this relationship of a third party.

Be a Lendthrift

We are engaged in a mortal struggle in which our way of life is at stake. In British Columbia are stationed thousands of young men upon whose health depends the future of our democracy. In our Province live many citizens whose civilian tasks in industry and in business are essential to an efficient national defence. It is our duty to see that the "fifth column" of illegally-operating, disease-dispensing, commercialized prostitution be not permitted to undermine the health of these important military and civilian persons. It is our duty to support vigorous inforcement of the Criminal Code in British Columbia. The business of commercialized prostitution in this Province must go! National Defence demands it! An improved public health demands it! Commercialized prostitution and its venereal disease are on the way out! Decent citizens will no longer tolerate this "fifth column".

Training of Volunteer Nursing Aids

(*Concluded from page* 19)

home nursing training as above but without having had the hospital experience.

A fourth group, not volunteer, would be the increasing number of ward helpers now being used to supplement nurses for various ward duties. These would be full-time employees on regular and recognized wage-schedules.

General Committee Being Formed

It should be further noted that steps are now being taken to set up a joint committee, for the duration, made up of representatives of the C.N.A., the C.H.C., the Canadian Red Cross Society and the St. John Ambulance Association. To this committee will be referred all matters relating to the hospital training or utilization of volunteer nursing aides.

Index of Advertisers

FEBRUARY, 1942